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—A special section

JUL 10 1950

Issues in Federal Health Legislation
—Albert V. Whitehall

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The Journal of the American Hospital Association

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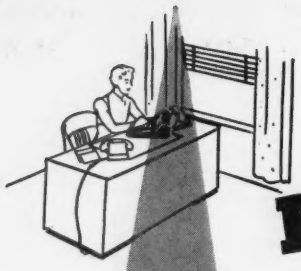

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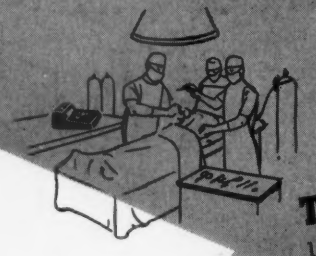

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IN THIS ISSUE

JULY • 1950

The Journal of

THE AMERICAN HOSPITAL ASSOCIATION

George Bugbee, Executive Director

VOLUME 24 NUMBER 7

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The issues in federal health legislation

Nearly a dozen major proposals are in the congressional hopper.

ALBERT V. WHITEHALL

CONGRESS WILL NOT act on compulsory health insurance this year. Congress is confused. So are the American people. Compulsory health insurance may be an issue in many local political contests this fall, but recently there have been some indications that it may not even be made a national issue as had been expected earlier.

One reason for confusion is that there have been nearly a dozen other proposals, each based on a different idea. Some of these proposals strive to avoid criticisms offered against compulsory health insurance. Others are attempts to develop a basic principle into workable legislation. Here, outlined in broad strokes, are the various proposals that have been introduced in the Eighty-first Congress.

H.R. 8746. *Sponsored by Representative Wolverton.* This newest proposal, introduced only last month, is in effect the embodyment of an idea presented by Harold Stassen in the *Reader's Digest* for April. The bill would set up a Federal Health Reinsurance Corporation, after the pattern of the Federal Deposit Insurance Corporation, with a three-member board of directors appointed by the President. This reinsurance device is commonly found in the insurance field, and its effect, when applied to the health insurance field, might be quite startling.

By reinsuring the heavier losses for health insurance, Representative Wolverton believes it will be possible for local Blue Cross, Blue Shield and other voluntary plans to give more attractive contracts to subscribers at a reasonable charge. "Within a brief space of time," he said, "this should cover the medical economic problem in the nation." A notable feature is that the government's contact with the program would be confined to the local nonprofit insurance associations. Mr. Wolverton says this bill will largely solve the nation's health problem "without bringing the government into the patient-doctor or patient-hospital relationship."

REPRESENTATIVE WOLVERTON

No more than two of the three members of the proposed Federal Health Reinsurance Corporation could be members of the same political party. Otherwise there are no qualifications for appointment. Initial financing would be by a $50,000,000 treasury appropriation, in exchange for capital stock. Each eligible health insurance plan choosing to participate would pay, in premium charges, 2 per cent of total gross payments received from subscribers. The corporation would pay two-thirds of each claim above $1,000 paid out by the plan for any period of 12 continuous months with respect to any individual subscriber. Prepayment plans, then, would relax contract limitations and offer broader coverage, knowing that the government would assume financial responsibility for two-thirds of the sum spent in excess of $1,000 in catastrophic cases.

Mr. Wolverton, incidentally, is a member of the powerful House Committee on Interstate and Foreign Commerce, and it was he who led opposition to the Hill-Burton Act in 1946.

S. 1679. *Sponsored by Senators Thomas, Murray, Wagner, Pepper, Chavez, Taylor, McGrath and Humphrey and Representatives Dingell and Biemiller.* The current compulsory health insurance bill, now known as the Thomas-Murray-Dingell bill, sometimes is referred to as the Wagner-Murray-

Mr. Whitehall is assistant director of the American Hospital Association and director of the Association's Washington Service Bureau.

REPRESENTATIVE KEATING

—Chase-Statler

REPRESENTATIVE BOSONE

SENATOR HUNT

Dingell bill. It is sometimes called the Truman bill, the Administration bill or the Ewing proposal because of its support by the President and the Federal Security Administrator.

This bill would require simultaneous enactment of a separate tax bill to levy a 3 per cent payroll tax divided equally between employer and employee. These funds would be gathered into a trust fund in Washington. An additional 1 per cent would be put in from the federal treasury. The trust fund would be administered by a National Health Insurance Board of five persons, including the Surgeon General of the Public Health Service and the Commissioner for Social Security. At least one of the five would be required to be a doctor of medicine, which means that the surgeon general might be the only physician on the board.

The National Health Insurance Board would divide the trust fund among the states by careful mathematical formulas based on comparative need, cost of services and other factors. Allocations to the states would be in five main categories: (1) Medical, (2) dental, (3) nursing, (4) hospital and (5) auxiliary services such as drugs, x-rays and false teeth. At this point one authority remarks, "It's easy enough to collect the money by imposing a tax. The hard part is the purchase of service. Solomon himself could not divide those funds to please everybody."

A sincere effort is made to "decentralize" administration. Doctors, hospitals and other participants would agree with such local administration as to methods of payment and other practices which could be determined at the local level. But decentralization would be subject to (1) the amount of funds allocated to states and local areas for purchase of services and (2) federal regulations.

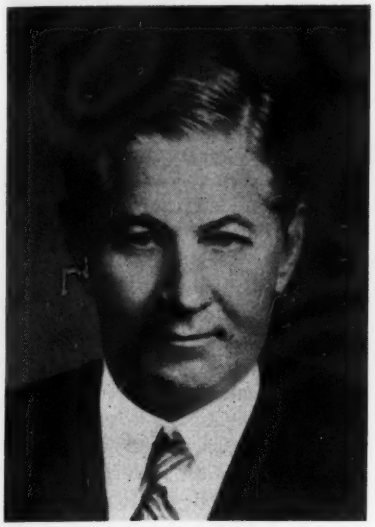
The compulsory health insurance bill makes no provision for indigent persons unless the local communities responsible for them pay premiums into the federal fund. It is generally recognized that the cost of fulfilling the promises made by this program would be stupendous and probably far in excess of estimates, although statisticians in the Federal Security Agency aver that they are immune to the errors that have plagued the British in a similar venture.

S. 1970. *Sponsored by Senators Flanders and Ives and Representatives Herter, Javits, Case, Nixon, Morton, Fulton, Hale and Auchincloss.* This is known as the Flanders-Ives bill. An article in *Fortune* magazine for March reviewed this bill and the compulsory health insurance bill with almost equal enthusiasm. Its sponsors are Republicans sincerely anxious to take a "liberal" viewpoint. Their advisers have patterned the program suggested along the lines of the Health Insurance Plan of Greater New York, which hires its own staff physicians to care for its members and purchases hospital care on a group basis. The Health Insurance Plan was sponsored by the late Mayor LaGuardia, and the majority of its members are city employees.

Loans and grants would be provided to start such small plans in communities and areas all over the nation. Enrollment in these small plans would be voluntary.

—Wide World

MR. STASSEN



SENATOR MURRAY

Premiums would be a percentage of family income.

A national "yardstick" would be established listing all the services that should be rendered by an ideal plan. In each state the state agency and health council would establish a norm. The norm would indicate the cost of providing "yardstick" services in the state. Thus, each community plan providing all the services listed in the national "yardstick" would be entitled to the state-established norm for the services provided to each subscriber. If the subscriber's income were so low that his contributions, based on a percentage of his income, did not reach the norm, the plan would receive a subsidy from state and federal funds.

Administrative provisions in this bill are most complex. At least one commentator has said it would be harder to administer than the compulsory health insurance bill. In this program, as in a compulsory health insurance program, doctors and hospitals would be under pressure to provide their services for prices beyond their control. Not every hospital would be able to provide its usual quality of care at the government-established norm.

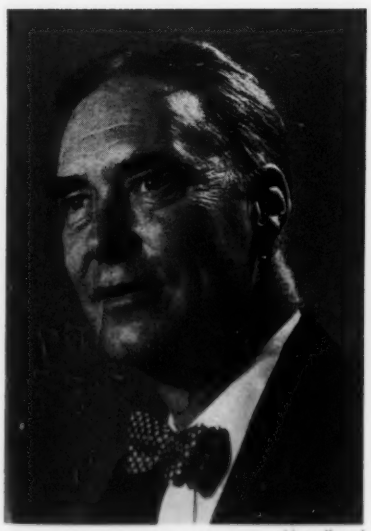
Some proponents of the compulsory health insurance bill believe this to be the next best thing to their own proposal, one reason being that it requires a majority of the members of governing boards of community plans to be persons who do not furnish health services. Although the sponsors of the Flanders-Ives bill believed it would help the Blue Cross plans, it seems that much smaller units are visualized and no means are apparent for preserving the stability that Blue Cross plans have obtained by reason of their coverage of large areas. The Flanders-Ives bill would grant subsidies to make up for differences in income. But an epidemic in a small plan area might throw great strain upon it, where a larger plan like Blue Cross would spread this risk over a larger area.

S. 1805. *Sponsored by Senator Humphrey.* Probably at the request of cooperative groups, Senator Humphrey introduced a bill to provide for loans to cooperatives wishing to establish their own programs of purchasing medical and hospital services. Brief hearings have been held by the Senate Committee on Labor and Public Welfare, but the bill has not attracted wide attention beyond cooperative groups and organized medicine.

S. 1106. *Sponsored by Senator Lodge.* In the Eightieth Congress and again in the Eighty-first, Senator Lodge has proposed that the federal government should pay half the cost of state programs to provide "certain medical services and medicines, which are standardized in their nature but which, because of their high costs, are not used in many cases in which their use in desirable." Medical aid would include x-ray, laboratory, diagnostic services, respirators and drugs. The state would be required to participate financially, and the Surgeon General of the Public Health Service would allocate federal funds on the basis of demonstrated need.

To those who believe that the distribution of health services can be solved by making health care less expensive, "across the board," this bill has had considerable appeal.

S. 2940. *Sponsored by Senator*



—Hans Knopf

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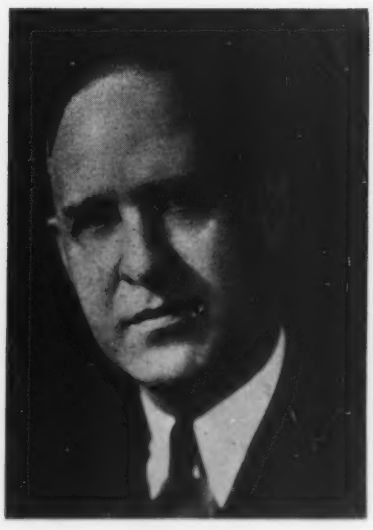
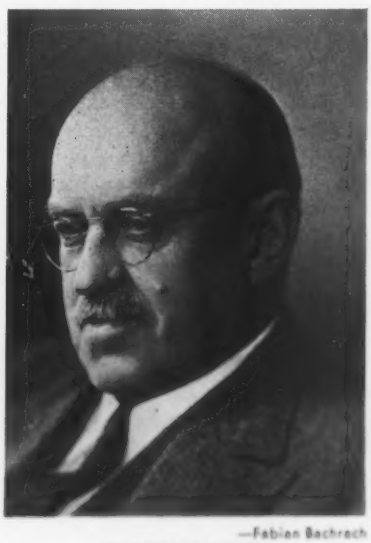


SENATOR HILL



—Fabian Bachrach

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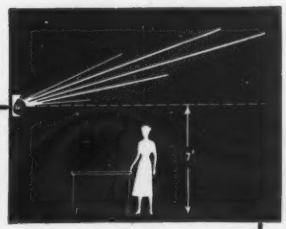

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HOSPITAL ASSOCIATION and ALLIED MEETINGS

American Hospital Association 52nd Annual Convention—September 18-21; Atlantic City.

REGIONAL MEETINGS

Maryland-District of Columbia-Delaware—October 30-31; Baltimore (Lord Baltimore Hotel).

Middle Atlantic Hospital Assembly—May 23-25, 1951; Atlantic City (Convention Hall).

Tri-State Hospital Assembly—April 30-May 2, 1951; Chicago (Palmer House).

Upper Midwest Hospital Conference—May 16-18, 1951; Minneapolis (Nicollet Hotel).

Association of Western Hospitals—April 30-May 3, 1951; Los Angeles (Biltmore Hotel).

STATE MEETINGS

Florida — Dec. 4-5; Orlando (Wyoming Hotel).

Illinois—Nov. 29-Dec. 1; Springfield (Abraham Lincoln Hotel).

Michigan—November 12-14; Detroit (Statler Hotel).

Nebraska—Nov. 16-17; Lincoln.

Ontario—October 30-November 1; Toronto (Royal York Hotel).

South Carolina—July 22; Myrtle Beach (Ocean Forest Hotel).

Washington—September 7-8; Spokane (Davenport Hotel).

OTHER MEETINGS

American Association of Blood Banks—October 12-14; Chicago (Stevens Hotel).

American Association of Medical Record Librarians—October 23-27; Boston (Somerset Hotel).

American Association of Nurse Anesthetists—September 18-21; Atlantic City (Ritz-Carlton Hotel).

American College of Hospital Administrators, 18th Annual Institute for Hospital Administrators—Sept. 5-15; Chicago (International House). Fellows' Seminar—Dec. 13-16; University of Chicago.

American College of Hospital Administrators—September 18-21; Atlantic City (Traymore Hotel).

American Congress of Physical Medicine—August 28-September 1; Boston (Statler Hotel).

American Protestant Hospital Association—Feb. 28-March 2, 1951; Chicago (Congress Hotel).

Association of Methodist Hospitals—Feb. 28-March 1, 1951; Chicago (Congress Hotel).

Blue Cross-Blue Shield Public Relations Conference—July 27-28; Chicago (Knickerbocker Hotel).

National Society for Crippled Children and Adults—Oct. 26-28; Chicago (Stevens Hotel).

Workshops on Financial Administration in Schools of Nursing, Conference of Catholic Schools of Nursing—July 24-28; Denver (St. Joseph's Hospital).
Nov. 20-24; Baltimore (Mercy Hospital).

INSTITUTES

(For additional information address Association headquarters, 18 E. Division Street, Chicago 10.)

Institute on Hospital Pharmacies—June 19-23; Ann Arbor (University of Michigan).

Institute on Hospital Laundry Management—June 26-30; Berkeley (University of California).

Institute on Hospital Personnel—July 10-14; Ithaca, N. Y. (Cornell University).

Institute on Hospital Purchasing—July 31-August 4; Palo Alto, Calif. (Stanford University).

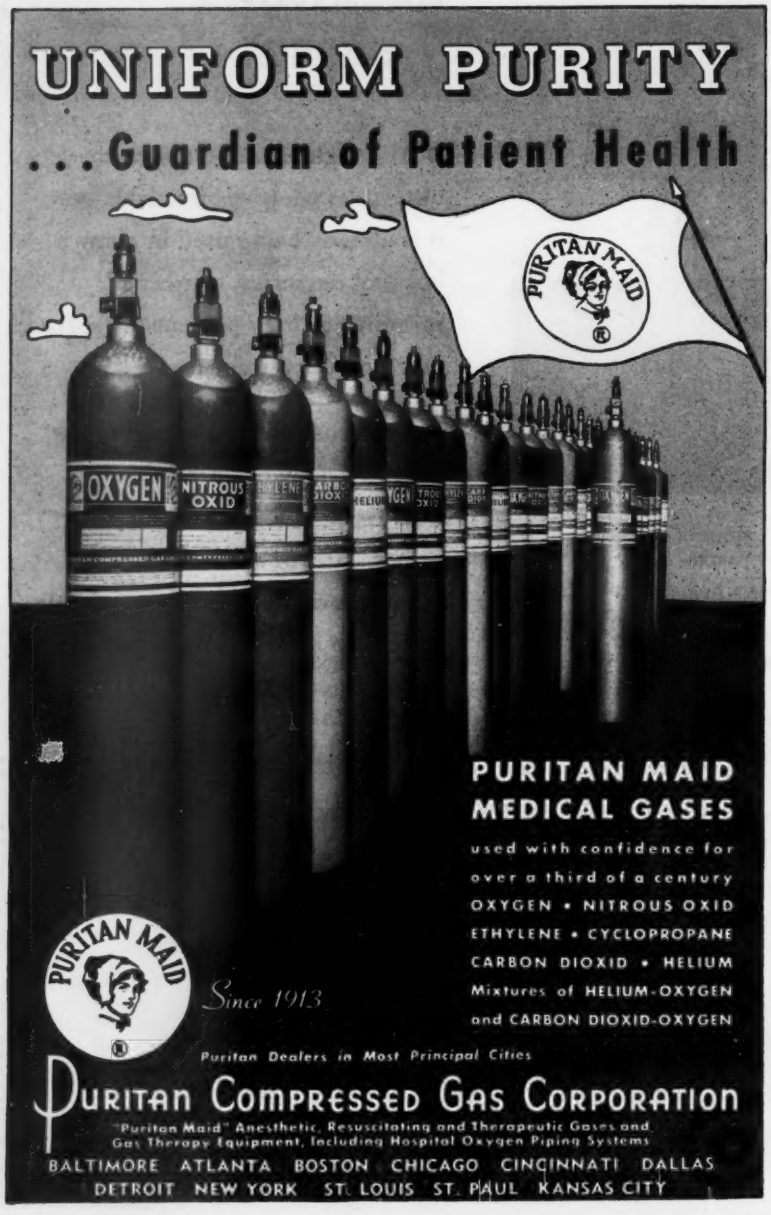
Institute on Medical Records—August 28-September 1; Chicago (University of Chicago).

Institute on Hospital Dietetics—October 9-13; Washington, D. C. (Wardman-Park Hotel).

Institute on Hospital Housekeeping—November 27-December 1; Chicago (Edgewater Beach Hotel).

Institute on Hospital Dietetics—December 4-8; Chicago (Stevens Hotel).

Institute on Hospital Planning—December 4-8; Chicago (Edgewater Beach Hotel).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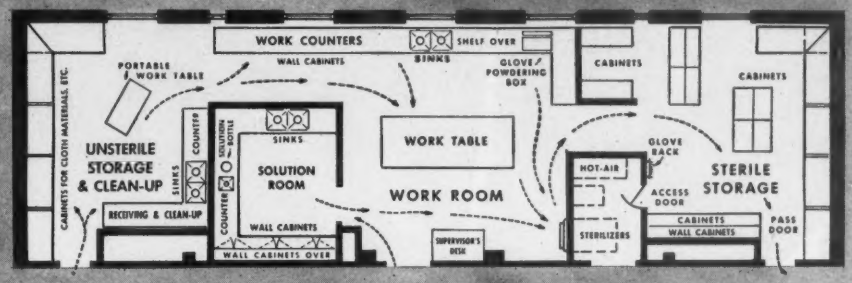

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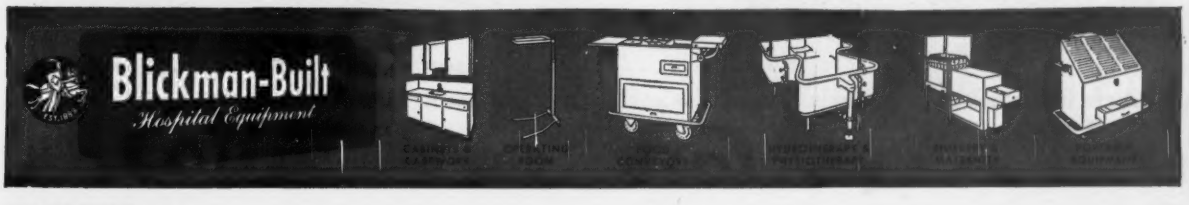

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Here full panel style Vari-Hite Bed is shown lowered to comfortable home height which gives convalescent patients a much greater sense of security. At low height there is no need for a footstool, no need to call the nurse for assistance, less danger of a misstep. Note that H-46 safety sides can be lowered even when the bed is in down position. Spring illustrated is Deckert Multi-position Spring but bed ends can accommodate any of the Simmons posture springs.

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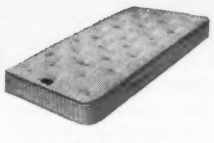
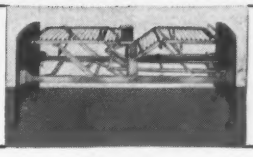
*** and for all other types of hospital beds, accessories and equipment it's SIMMONS, too!**



Beautyrest hospital mattresses

Simmons H-800-1-L-190 Self-adjusting Bed



Simmons H-806-L-171 Eye Bed

Simmons flat spring infirmary bed H-600-SCC-H-50

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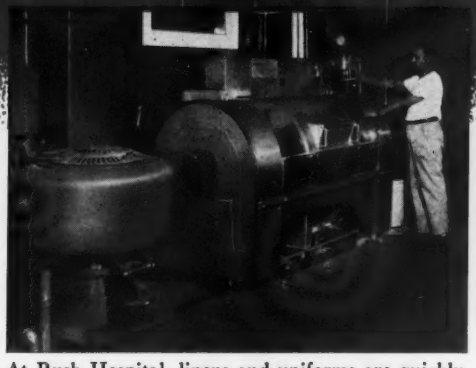
CONGRATULATIONS to

Rush Hospital, PHILADELPHIA

On Its Compact, Modernized Laundry Department



At Rush Hospital, linens and uniforms are quickly washed sterile-clean in Monel metal CASCADE Washer, *right*. At *left*, Solid Curb Extractor for removing excess water from washed work.

On opposite side of laundry room, ZONE-AIR Tumbler *(left)* fluff-dries linens not ironed. RETRON Flatwork Ironer *(center)* irons sheets, pillow slips, etc. At *right*, one of 2 presses in special Press Unit for ironing nurses' and staff uniforms.

PROBLEM: This 168-bed hospital was faced with necessity of replacing old, costly-to-operate laundry equipment which could no longer supply adequate volume of clean linens.

SOLUTION: Our Laundry Advisor was asked to study the problem and submit recommendations. He carefully analyzed volume of linens required for each hospital department. He then prepared plans for a modern laundry, utilizing up-to-date equipment of proper type and capacity to best meet hospital's particular needs.

RESULTS: Hospital reports exceptionally fast laundering at low cost with new equipment. Ample reserve supplies of sterile-clean linens and uniforms are always maintained in all hospital departments for any emergency. Yet laundry work hours have been reduced. The neater, more attractively laundered linens and uniforms are especially pleasing to patients and staff.

Our Laundry Advisor will gladly study your clean linen problem and submit recommendations. No cost or obligation. WRITE TODAY.

Remember... **Every department of the Hospital depends on the Laundry.**

• • •

Your hospital will benefit by selecting from our complete line of most advanced and productive hospital laundry equipment.

RETRON Flatwork Ironer at Rush Hospital quickly irons sheets and all other flat linens, with a beautifully smooth finish. Compactly engineered design and safe, simple operation make RETRON particularly suitable for smaller hospitals. Ironed linens are returned to operators at feed side, so ironer can be installed against wall for added space savings.

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LAUNDRY MACHINERY CO.

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IN THEIR TRAVELS about the country attending conventions, the Hatfields have been fortunate in that, for the most part, weather conditions were good. Of course it was better luck than good management, but there is the possibility that those responsible for the several programs had something to do with it. At any rate, the trip to Charleston, S.C., where the Carolinas-Virginias Hospital Association convention was held early in May, was everything to be desired. The same can be said of the jaunt to Buffalo, N.Y., for attendance at the meeting of the Middle Atlantic Hospital Assembly later in the month.

During May, Mrs. Hatfield and I resorted to the automobile as a means of transportation to and from our convention assignments. We joined Bert Whitehall in Washington on the ninth for a fast but nevertheless delightful drive down the east coast to Charleston. We returned to Philadelphia the evening of the thirteenth. With little urging and not much effort I could wax enthusiastic about that old and fascinating city of Charleston. We saw just enough of it to want to return for a leisurely visit in the not too distant future. We have pledged ourselves to do just that.

One of the disadvantages of conventioning is the lack of time to see all the interesting spots of the host city. Bert Whitehall and I had the good fortune, however, of being piloted hurriedly about Charleston by Monsignor George Smith, Diocesan Director of Catholic Hospitals, Aiken, S.C., who claimed residence in that historic city for several years. He demonstrated an unusual knowledge of the bay area.

Additionally, the Hatfields had a couple of short tours with Jennie Jones, who made good use of the family car while Ev was busy "covering," or participating in, the convention program. Bill Lowrance, president, and Jacque Norman, chairman of the program committee, aided and abetted by a corps of Association old-timers, are to be complimented on a job well done despite what seemed to me to be a rather poor attendance record. This nonattendance could very well be accounted for because the Carolinas-Virginias area is large and the convention was held way off center geographically.

I was back in my office only a few days—just long enough to sort an accumulation of mail and put the finishing touches on the 1950-51 budget—then off again by automobile to Buffalo for the Middle Atlantic Hospital Assembly. This trip my wife and I took by easy stages, stopping off in the village of Tioga, Pa., to see my mother both going to and returning from Buffalo. We also visited a young nephew who is starting a general medical practice in a small town upstate. I mention this latter incident because it was there that I had my fill of brook trout. Potter County, Pa., is noted for its wild game, and experienced fishermen have no difficulty in catching the daily legal limit of native speckled beauties.

It seemed to me fitting that I should end my convention schedule by attending the Middle Atlantic

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AN AID IN CONTROL OF INFANT DIARRHEA

Terminal processing of formula at 230° requires a time factor of 10 minutes. Such a short period is recommended because of possible damage to the milk. The danger in use of such a ***short*** 10 minute exposure (general autoclaving requires 30 minutes) can be offset by use of new Inform Controls. Thus if the milk is slow in heating inside the bottles Informs will tell you. If your autoclave is not highly efficient and the thermometer is incorrect Informs will tell you.

In general you will find Informs as necessary as Diacks because you are working on ***"the edge of sterilization"***.

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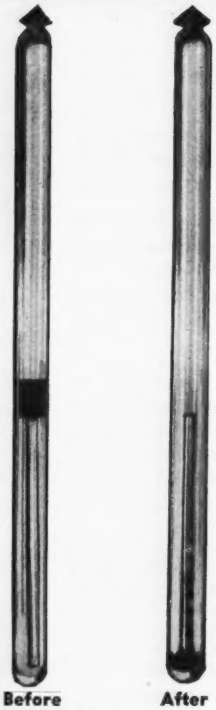

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ABSOLUTELY NEW! WEBRIL is the first and only true, non-woven, all-cotton felt! The result of years of research, released recently by Bauer & Black, WEBRIL Bandage has been thoroughly tested and approved *in use* by hundreds of doctors!

CONVENIENT!

Can be torn neatly by hand for application, yet will not tear or fray easily on patient. Holds together, wet or dry—won't shrink! And it's smooth, soft, non-skid!

MANY USES!

WEBRIL Bandage is perfect as a general utility bandage! And it can be used in place of sheet wadding, crepe paper, wool felt, stockinette in cast application.

CONFORMABLE!

WEBRIL Bandage clings to itself, not the patient. Adjusts to body contours, won't wrinkle, does not wad or bunch up. Extremely porous and absorbent. Gives mild support.

EASILY APPLIED!

Simply wind WEBRIL Bandage around a limb, you don't have to hold it in place for each layer clings to the one below. Easily cut, quickly applied, lint-free.

COMPLETELY USABLE!

No waste necessary—odd lengths can be used as padding. Merely rub them on, they stay where placed.

Ask your Curity Representative About New WEBRIL Bandage!

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Division of The Kendall Company, Chicago 16

RESEARCH TO IMPROVE TECHNIC...TO REDUCE COST

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Hospital Assembly, comprising the states of New York, New Jersey and Pennsylvania. It had all the aspects of a homecoming week, for I was with men and women with whom I have been closely associated many years. Moir Tanner, president of the assembly, was in his usual good form, and you may be sure the program was of fine quality as it was arranged by an experienced committee headed by John Hayes. I had the pleasure of addressing the assembly as well as the record librarians' association.

AT THE BANQUET of the Middle Atlantic Assembly I was caught way off base—surprised as completely as the most unsuspecting person ever was. It turned out to be one of the nicest things that ever happened to me. I was presented with a beautiful wrist watch, complete with an appropriate gold band to match. It was a gift from members of the Hospital Association of Pennsylvania, the presentation having been made in their behalf by President Willard Butts, a good and true friend of many years standing. I should like to take this means of expressing heartfelt thanks to my fellow Pennsylvanians for this token of friendship which I shall treasure as long as I live.

I AM ADVISED by American Hospital Association headquarters that the Atlantic City convention in September promises to be a record-breaker from the standpoints of expected attendance, program coverage and commercial exhibit acreage. Those who plan to attend and have delayed arranging for hotel accommodations should act promptly. Atlantic City is renowned for its hotel facilities and there is little chance of a room shortage, but you may be sure that rooms in the hotels within short walking distance of the Convention Hall will be reserved early.

ADDRESSING assemblages at conventions in all parts of the country these past several months I have talked, among other things, about some of the things that concern me. I have placed emphasis on my concern about the public's insistence that hospital rates are too high, which is just another way of saying hospital costs are too high. We squirm uneasily when we hear the accusation, whether the statements are made orally or written. We do hear them often and we do read them in magazine articles and in the press. We have no one but ourselves to blame, because collectively we are doing relatively little to enlighten the public. Rates do seem to be high, particularly to those who are hit by catastrophic illness, unprepared to finance its cost. No one wants to go to a hospital as a patient; yet, faced with health impairment or even death, one goes and is the recipient of highly scientific treatment and specialized care of as complicated an organization as one can imagine. But is the public informed about the ramifications of hospital service? Is it made conscious of the highly technical procedures involved in patient treatment—administered by highly trained specialists and involving highly specialized equipment? The answer is that we just do not tell the public what we are doing, what our problems are, what our costs are.

LET US STOP TALKING about per capita per diem costs and, instead, emphasize cost per hospital stay. Let us demonstrate how immeasurably better off the patient is today than he was 20 or 25 years ago. Let's show how the stay has been shortened during that period, how much less time the wage earner is away from his paying job, how much better are his chances of leaving the hospital completely cured, how the life span has been substantially lengthened. Let us emphasize how all this has been made possible by our hospitals. Let us demonstrate, too, that hospital costs have not kept pace with the increased cost of living. We must give the public true facts.

John N. Hatfield, President,
American Hospital Association

The Campbell Bed Lamp clamps to the angle iron of the head section on any hospital bed; therefore permitting a perfect reading position at all times regardless of degree of elevation.

The Campbell Bed Lamp is fully adjustable through flexible joints and since it is easily detachable from its base, the lamp can be used for examinations. When turned upward, The Campbell Lamp provides an excellent night light.

Available in white, brown or green baked enamel finishes. Price . . . $9.00

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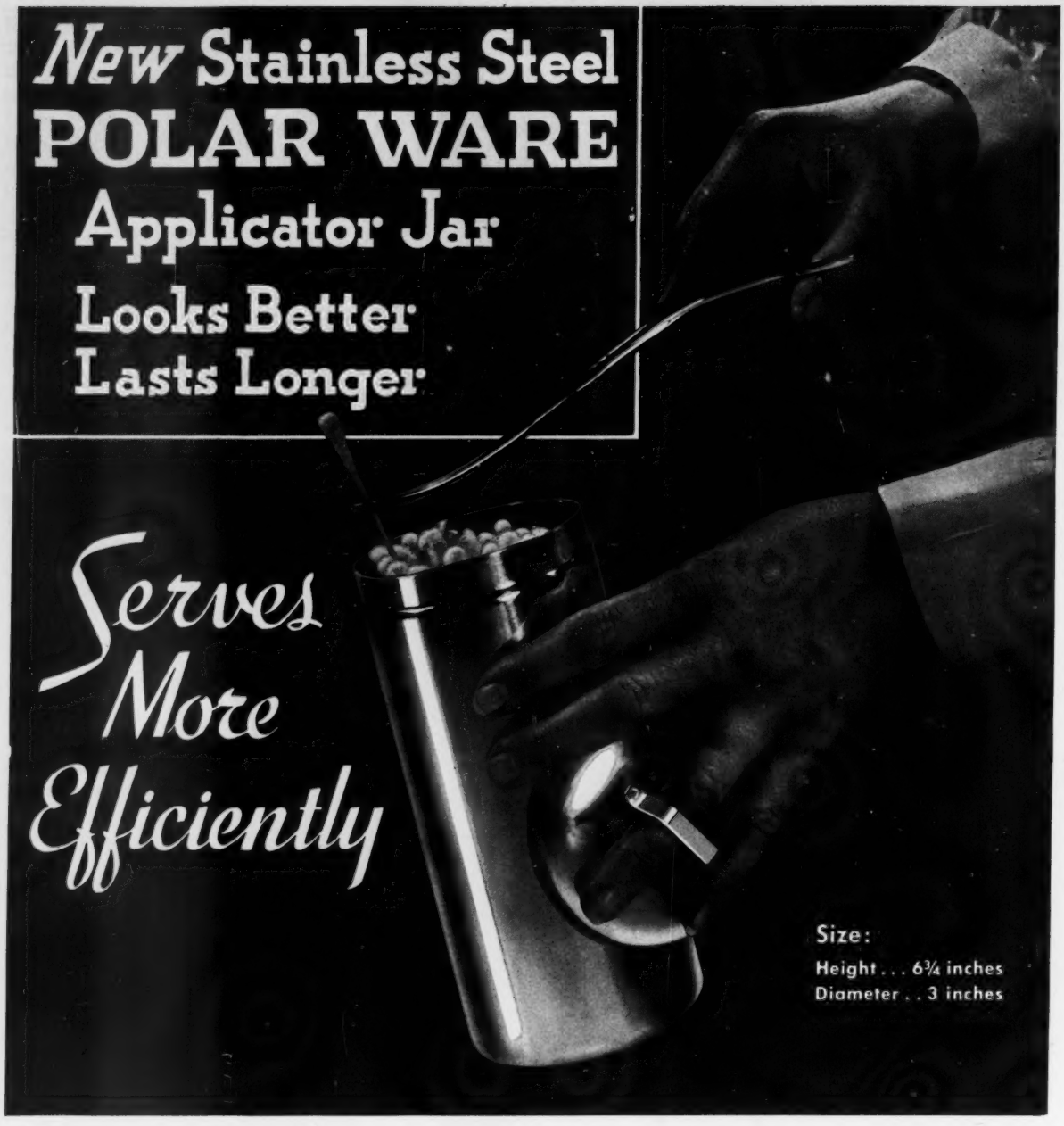
Looks Better Lasts Longer



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Size:
Height . . . 6¾ inches
Diameter . . 3 inches

You'll appreciate all the advantages of this easily handled applicator jar, unbreakable and almost dent-proof—a jar that outlasts other types by many years because accidental drops can't harm it.

In addition to the strength and durability found only in stainless steel, the new Polar Ware applicator jar has the shining beauty of sterling silver. The inside finish is mirror-smooth—result of "polishing" by the electronic process. This advantage, combined with rounded corners, simplifies cleaning and guarantees sterility.

The Polar Ware applicator jar matches your finest clinical equipment . . . helps recommend your service to physicians and patients alike. By any test, it meets the quality standards of the established Polar Ware line, carried by leading hospital supply houses from coast to coast. Request information from the men who call on you.

The Polar Ware line is complete—hospital ware in stainless steel and triple-coated porcelain enamel on steel.

Polar Ware Co. 3500 LAKE SHORE ROAD SHEBOYGAN, WISCONSIN

Indication:

HAY FEVER

Therapy:

BENADRYL®

This is the season when bleary-eyed, sneezing patients turn to you for the rapid, sustained relief of their hay fever symptoms which BENADRYL provides.

Today, for your convenience and ease of administration, BENADRYL Hydrochloride (diphenhydramine hydrochloride, Parke-Davis) is available in a wider variety of forms than ever before including Kapseals®, Capsules, Elixir and Steri-Vials®.

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A BACTERICIDAL SOAP

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In Office, Home, Operating Room and All Cleansing Procedures

You'll say it's a top quality bar of hard-milled soap—yet its ingredients give results never obtained from any soap.

Gamophen contains hexachlorophene (2%),* the most effective, longest-acting skin antiseptic known. The soap base was specifically selected to provide optimum release of hexachlorophene's bactericidal properties, without irritating or drying the skin. Gamophen has been tested in 3½ years of laboratory and clinical evaluation.

Prolonged Antibacterial Effect

Hexachlorophene exerts a prolonged antibacterial effect against resident flora of the skin, gram-positive and gram-negative organisms, pathogenic and non-pathogenic bacteria.

Several investigators have found that the standard scrub of 15 or 20 minutes may safely be reduced to from 3 to 6 minutes when Gamophen is used.

In a series of comparison tests it was found that the bactericidal action of Gamophen was 36% greater against mixed cultures of S. aureus,

*"Hexachlorophene" has been accepted by the Council on Pharmacy and Chemistry of the American Medical Association as the generic term for dihydroxyhexachlorodiphenyl methane.

WHAT YOU GET IN GAMOPHEN

Bactericidal action.
Sustained low count in regular use.
Emollient effect—no irritation.
Quick, rich lather in any water.
Economy—less than half the cost of liquid soap.
Tremendous Time Saver—3-minute scrub is sufficient.

GAMOPHEN ANTISEPTIC

ETHICON SUTURE LABORATORIES
INCORPORATED
NEW BRUNSWICK, NEW JERSEY

AND HOSPITAL PERSONNEL

Emollient, Rich-Lathering, Fast-Acting
Continuously-Effective, Economical

S. hemolyticus and E. Coli, and 10% greater against Cl. welchii, than 3½% tincture iodine.

When used routinely for all cleansing occasions in hospital, office and home, Gamophen establishes a protective anti-bacterial film which exerts a continuous action. The marked degree of suppression achieved is maintained as long as this soap is used regularly and for several days after its use is stopped. The use of alcohol or other solvent rinses is contraindicated.

Bactericidal in 3-minute Scrub

Gamophen Soap is alkaline in solution, with a pH of 8.5 to 9. It is bactericidal in a 3-minute scrub in the concentrations used in normal scrub conditions. It quickly produces a thick, rich lather, even in hard and cold water. Every lot produced is tested for potency.

In other tests, hexachlorophene in Gamophen was found to be more effective than it was in other vehicles, such as certain liquids having an acid pH, in which it is bacteriostatic but not bactericidal. Liquid solutions having an acid pH lower the effectiveness of hexachlorophene.

Gamophen is supplied in 4½-oz. bars for home and office; in 2-oz. bars for hospital personnel and patients' use.

WHERE TO USE GAMOPHEN

In office and home.
In the hospital wherever soap is used—by staff personnel or patients.
For pre-operative antisepsis of skin.
Industrial clinics and first aid stations.

SOAP

SOLD ONLY THROUGH SURGICAL DEALERS

FREE—FULL-SIZE BAR FOR TRIAL

(May be clipped and pasted to Penny Post Card)

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TAGATHEN* Chlorothen Citrate *Lederle*

and POLLEN ALLERGY

DESCRIPTION—Allergy to pollens occurs chiefly in either May and early June, or in August and September. According to the climate in various parts of the country, the season may be more extended. Allergic rhinitis, urticaria, sense of constriction about the chest, sneezing, and in the late stages, asthma, are prominent in the symptomatology.

ETIOLOGY—By far the most common etiologic agent is ragweed, but sensitivity to many other pollens is fairly frequent. Other common offenders are timothy, Bermuda grass, sagebrush, pigweed and Russian thistle, as well as various trees. The mechanism of allergy is unknown, but it would appear to be associated with the release in excessive quantities of histamine, which is combatted by the administration of antihistaminics.

LABORATORY DIAGNOSTIC AIDS—Skin testing is a reliable index both qualitatively and quantitatively of pollen allergy. These tests are applied preferably by the scratch test technique before initiating any desensitization or therapeutic program. POLLIGENS* Allergenic Extracts Quantitative Tests *Lederle* are a highly simplified method for the diagnosis of pollen allergy.

DURATION—Allergy, once developed, usually persists throughout life. However, its effects may be greatly ameliorated by the administration of such antihistaminics as TAGATHEN Chlorothen Citrate *Lederle* and by desensitization procedures with POLLIGENS Allergenic Extracts Treatment *Lederle*.

PROGNOSIS—The prognosis for pollen allergies is excellent in most cases, under good management. The appearance of persistent bronchial asthma, however, that resists therapeutic measures, definitely alters the prognosis unfavorably.

THERAPY—Desensitization programs are mandatory if the exposure is severe, or the reaction to exposure is marked. The degree of sensitivity of the patient, as revealed by scratch tests, tends to indicate whether desensitization is essential. In mild cases, symptomatology may be controlled by the administration of TAGATHEN in a dose of 25 mg. 4 times a day. If the patient does not improve, the dose may be increased to not more than 50 mg. given 4 times daily. A feeling of drowsiness is not uncommon following the use of such drugs and persons on full dosage should not operate any vehicle.

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Bottles of 100 and 1000 tablets, 25 mg. each tablet.

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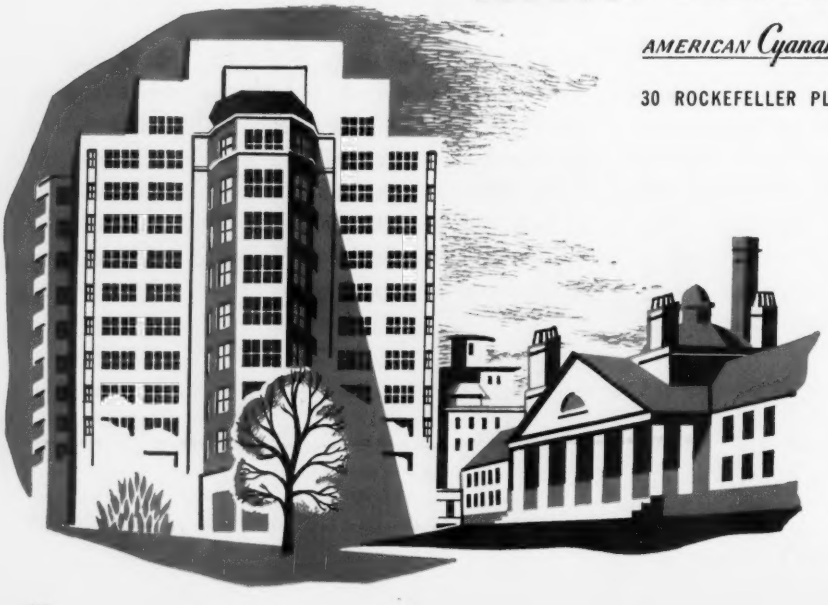

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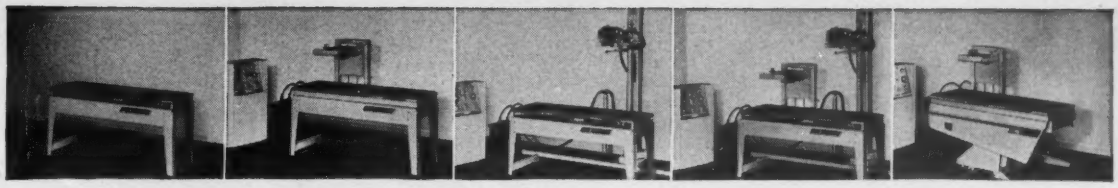

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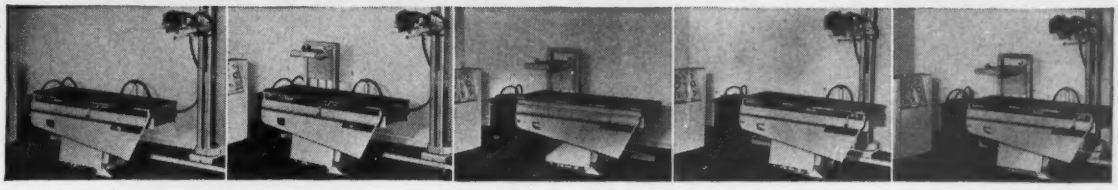

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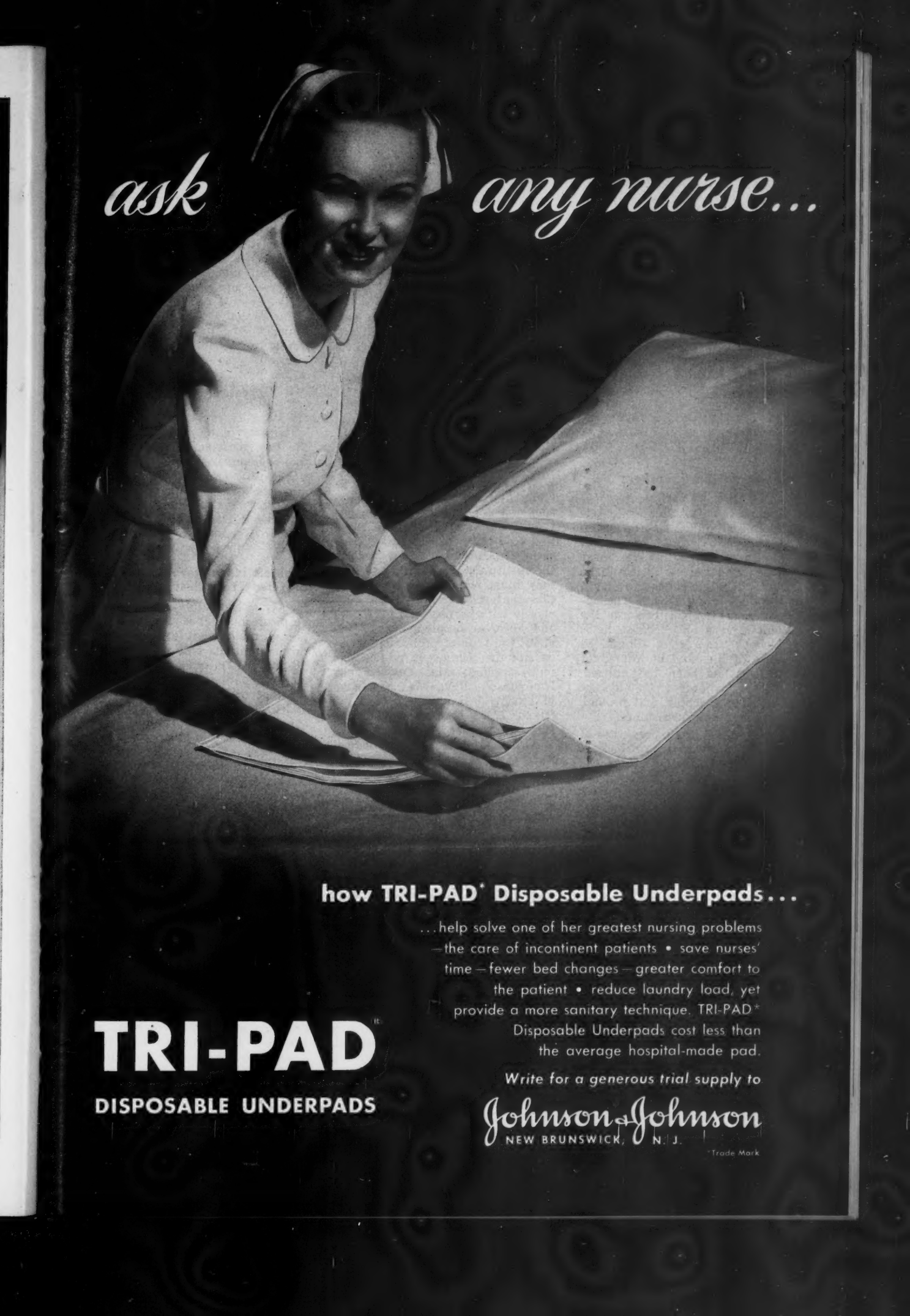
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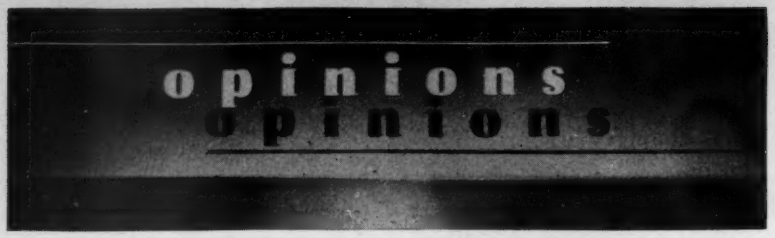

ON PREVENTING FALLS FROM BEDS

AMONG THE PROBLEMS of a hospital is that of patients' falling out of their hospital beds. Every hospital has its own way of dealing with this problem, and representatives of four hospitals present below their answers to the question: "In terms of equipment, standard procedures and education of employees, what combination of precautions do you find most effective in minimizing the hazards of patients' falling out of bed?"

Training auxiliary workers in protective measures

ACCIDENTS IN WHICH hospital patients fall out of bed may be classified into two groups. The first group of accidents involves those patients who are permitted to be up but fall while getting in or out of the high hospital beds. The accident may happen because the patient is very old, because he is still weak from long illness, or because of the kind of injury for which he has been hospitalized. For these patients a footstool at the bedside probably will provide all of the needed assistance.

The second group consists of those patients who are on bedrest and inadvertently fall from the bed. The following patients are the ones who need protection to prevent this type of accident:

1. Elderly patients, especially those who have received sedatives.
2. Post-operative patients until fully awake from anesthesia.
3. Patients who have had neurosurgery.
4. Patients who are blind or have their eyes covered.
5. Patients who are semi-conscious, unconscious, or comatose.
6. Patients who are disoriented or suffering from vertigo.

The following measures have been found to be most effective in minimizing this hazard:

1. Side rails. The removable type that is made to fit the bed exactly and can be let down by use of a special spring arrangement has been found to be most safe and time-saving. These are applied routinely to the patients listed above at the discretion of the nurse.

2. Footboards. These must be applied in combination with side rails for patients who might try to climb over the foot of the bed.

3. Restraints. Muslin or leather straps are applied to the extremities as an additional measure for those patients who are disoriented or agitated and for whom side rails are not sufficient.

The education of the auxiliary workers in the proper use of protective measures is a serious problem. They should not be held responsible for knowing when a patient requires special attention of this kind unless an extensive educational program is carried out in the institution. In addition to this, they must be impressed with the fact that they should work very closely with professional personnel and receive detailed instructions about the type of protection needed and the manner in which it is to be applied.—MRS. OLIVE FROST RICHARDSON, R.N., MRS. INGEBORD MAUKSCH, R.N., EVELYN VAN DE STEEG, R.N., MARIAN G. MILLER, R.N., CONSTANCE AMESBURY, R.N., and IDA GINDELE, R.N., *medical nursing instructors, St. Luke's Hospital, Chicago.*

Educational program makes employees alert to danger

HOSPITALS HAVE LONG been faced with the problem of patients' falling out of bed. This hazard, along with that of hot water bottle burns, probably accounts for more lawsuits involving hospitals than all other risks combined. Administrators have tried many schemes to lessen the number of accidents of this type.

In approaching this question let us first consider the matter of education. In order to reduce these mishaps, it is absolutely necessary that subsidiary attendants, as well as nurses, be taught to understand what to do and also to recognize immediately that the patient is in jeopardy. This should be included in any training program or orientation period.

One hospital has gone so far as to ask the members of the medical staff to attach to the chart a checklist on which is included a notation as to whether or not side rails are desirable or if special attention is needed. In this way the hospital asks the doctor to share the responsibility for this risk. Of course it is academic to discuss the use of side rails, but it should be noted that in some instances side rails are used routinely on post-operative patients.

The proper arrangement of furniture in the patient's room will lessen the possibilities of serious injury in case of a fall. Also, one of the best arguments for placing the patient's bed next to the wall is that it does minimize the chances of having an incident of this type.

It is my opinion, however, that the best manner of dealing with this problem is through an educational program, making the employees keenly conscious of this peril and alert for signs of danger. —FRANK S. GRONER, *administrator, Baptist Memorial Hospital, Memphis.*

Problem is met through adult crib beds, rails, insurance

PATIENTS FREQUENTLY FALL from hospital beds because of: (1) Faulty assignment of patients to proper sections and wards in the hospital; (2) inadequate equipment in patients' rooms, and (3) shortage of professional personnel and its lack of proper training.

Many hospitals continue to be overcrowded. In such cases the admission officer seldom has the opportunity to assign patients to the section or ward in the hospital best fitted to care for the individual who is most likely to be in danger of falling out of bed. When facilities are again adequate it will be an easy matter to plan intelligent admission schedules so that elderly people and those suffering from conditions causing extreme restlessness can be put in rooms or wards equipped for this purpose and close to nurses' stations where more frequent bed checks are possible.

A 36-inch hospital bed is not wide, and its very height constitutes a hazard. Bare terrazzo floors, common in most modern hospitals, do little to cushion a fall. It is therefore necessary to guard against sagging mattresses, faulty casters and slipping foot stools that may cause unexpected falls. Today's modern hospital bed seldom causes trouble, but it should

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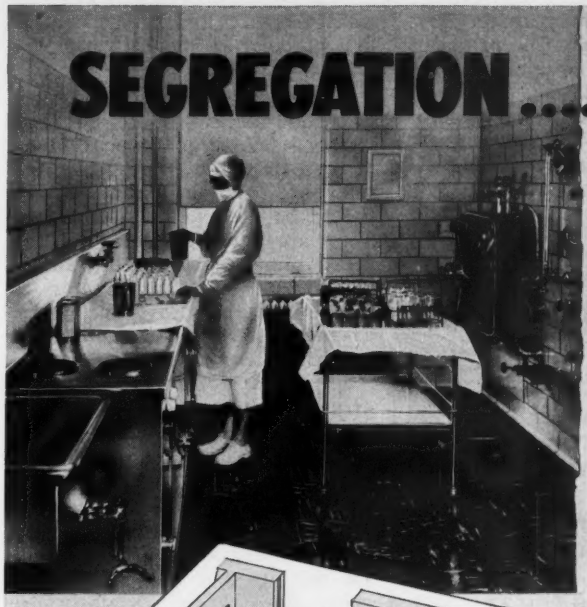

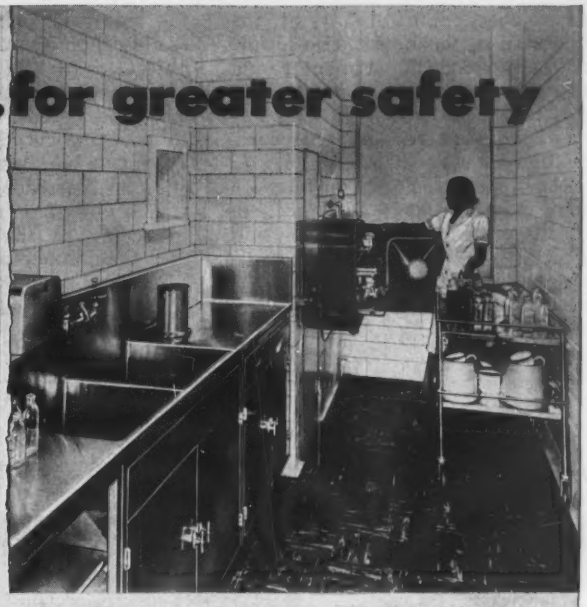

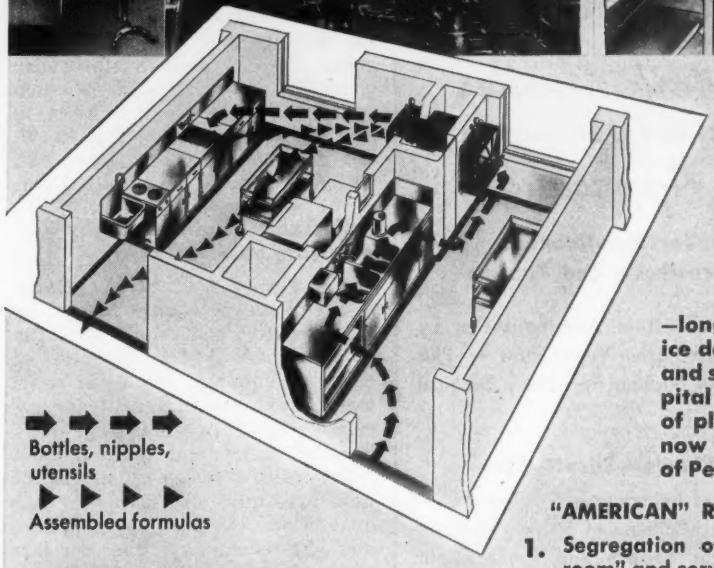

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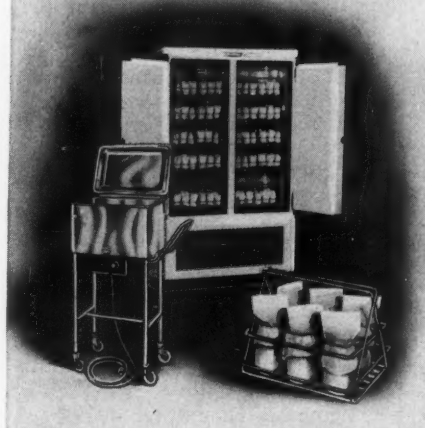

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be replaced immediately at the first sign of weakness. The hospital maintenance department should schedule a periodic inspection of patients' beds and allied equipment so as to keep the furniture in the best state of repair.

For the old and disturbed patient some hospitals have had excellent results with using adult crib beds. The built-in rails allow immediate raising and lowering as the need requires, and the height of the side rails is much more protective than average. The primary objections to the equipment are:

1. Cost of installation.
2. The refusal of some people to use the bed since it reminds them of a child's and suggests that they are not capable of caring for themselves. This objection is soon overcome as the equipment becomes commonplace. In our hospital, bed falls have been reduced to a minimum where such equipment was installed five years ago in a ward for old men in a urological department.

Personnel, professional and their auxiliary helpers, must be constantly schooled in the importance of a "safety first" program. Bed rails are always available and should be used first and not last. They are easily removed if they prove unnecessary. Such training is the duty of the director of nurses and the floor supervisors. The administrative officers can aid materially with their efforts in many ways. Some hospitals have arranged annual safety lectures prepared by their insurance carrier, which are given before groups of all classes of personnel.

There are leaks in all "safety first" programs, and it is intelligent administration to secure ample liability and malpractice coverage with a reliable insurance company. The existence of such protection is a great comfort to any hospital board. — DONALD W. DUNCAN, *business manager, St. Elizabeth's Hospital, Lincoln, Nebr.*

Adjustable height beds may eliminate some accidents

A STUDY OF THE FACTORS related to accidents to patients caused by falling out of bed should have the objectives of: (1) Determination of cause, frequency, time of day, ward having the highest incidence, relationship between average daily nursing hours and accident and relationship between orientation of new personnel and accident: (2) evaluation of present program, and (3) recommendations for improvement.

The first step in the improvement of physical facilities is the provision of adjustable height beds or regular beds that lower by caster removal for the patient who is disturbed by the unfamiliar hospital bed. The high and narrow bed is a hazard as any patient may lose balance while turning, trying to reach the bedside stand, or attempting to rise without assistance. Often a gentle reminder is all that is needed, and sufficient restraint is afforded if top covers are tucked in, if sheets are folded on the bias and placed across the chest and thighs and if soft cloth wristlets are applied.

Emphasis should be placed on individual attention from adequate personnel, making patients comfortable, eliminating disturbing factors and orienting the patient.

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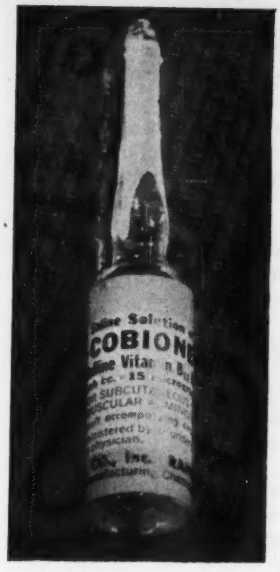
quate limitation of activity for the post-operative, elderly, heavily-sedated, or critically ill patient, the use of crib sides is advisable. Only in the extreme case and on order of the physician is more rigid physical restraint indicated.

Routine procedures must include a report of the accident to those in authority. Its value is derived from the fact that immediate medical attention is encouraged, personnel is alerted and information is gathered for hospital and insurance company files. Currently recorded information is valuable in delayed legal proceedings. Full cooperation with the insurance carrier is important.

Clinics, conferences and classes on accident prevention are helpful in the education of employees. Obvious carelessness must be overcome. Positive methods must be emphasized to familiarize the personnel with existing conditions and improvement methods.

The variety of medical and surgical patients in a general hospital represents different ways of experiencing illness. The patients present many psychiatric problems. In the restlessness, apprehension, confusion and disorientation of the decompensated cardiac, the confused pneumonic, or the individual with barbiturate intoxication, there is often an insistence on getting out of bed. There are measures that prevent development of such conditions in some cases and relieve and hasten their disappearance in others. Since not all toxic patients develop delirium, it may be assumed that part of the etiology lies in psychological factors, for which there are better than mechanical restraints.

A patient showing personality alterations must have treatment that is given by persons who have the ability to recognize and effectively deal with them. An objective and tolerant attitude is important but not enough. We must attempt to establish a personnel-patient relationship that will comprehend the patient's psychological pattern and anticipate and satisfy his needs. This is a real contribution to his care and the best restraint to prevent falling-out-of-bed accidents.—NELL ROBINSON, *superintendent, The East Liverpool (Ohio) Hospital.*



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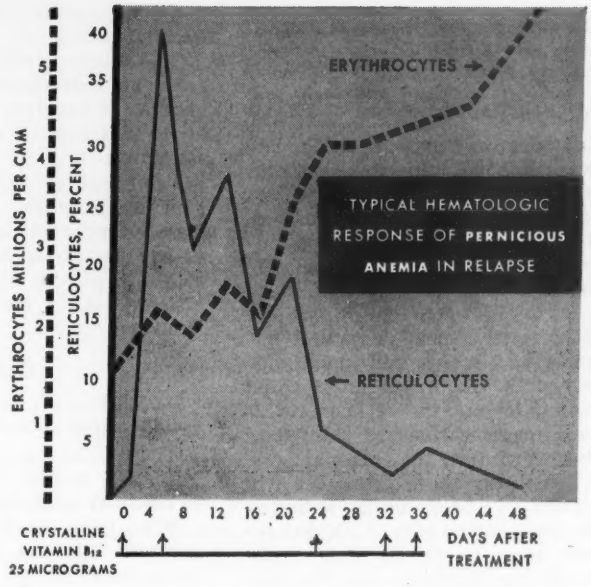
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Social security

(Note: At presstime, Congress was taking action on H.R. 6000, and the results will be reported in the August issue of HOSPITALS.)

What is the general reasoning behind changes in H.R. 6000 recommended by the Senate Finance Committee?

Church groups have been jealous of their freedom from taxation and felt that compulsory social security contributions might be interpreted as taxation. This issue was compromised in H.R. 6000, which gave the nonprofit institution (including church institutions) the option of waiving their exemption for social security contribution purposes. This provision in H.R. 6000 was approved by the American Hospital Association, the Catholic Hospital Association and the American Protestant Hospital Association. The nervousness of some church groups, however, has continued, and it seems to have been due to this apprehension that the Senate Finance Committee acted to exclude religious institutions entirely from the Social Security Act.

The Senate Finance Committee has reconsidered its action on the basis of solicitations by church groups who are anxious to have their employees protected. The present recommendation of the Senate Finance Committee is to make social security coverage optional for religious institutions and mandatory for nonprofit institutions. But, in this case, the option would be as to contributions of both employee and institution. The institution would decide whether employees are to be covered or not. There is a possibility that when the bill comes to the floor of the Senate the provision of H.R. 6000 will be followed rather than the recommendations of the Senate.—ALBERT V. WHITEHALL.

Prophylactic in babies' eyes

What states have laws pertaining to the use of prophylactics in the eyes of newborn babies?

The District of Columbia and all of the states except Utah have laws or regulations requiring the use of a prophylactic agent in the eyes of the newborn.

In most instances the law either leaves to the discretion of the state health department the type of prophylactic agent to be used or specifies "1 per cent silver nitrate or equally effective agent."

Since the discovery of penicillin, there has been discussion of substitution of penicillin for silver nitrate as a prophylactic against ophthalmia neonatorum. The *American Journal of Public Health* published an article, "Penicillin or Silver Nitrate as a Prophylactic Against Ophthalmia Neonatorum," in December 1948.—DR. CHARLES T. DOLEZAL.

Hospital specialists' salaries

Do you have any information on satisfactory arrangements in regard to compensation between the individual hospital and its radiologist, pathologist and anesthesiologist?

Satisfactory arrangements between the individual hospital and its radiologist, pathologist and anesthesiologist are not easily settled. The best general guide to the settlement of these negotiations is embodied in the "Principles of Relationship between Hospitals and Radiologists, Anesthetists and Pathologists," which still stands approved by the American Hospital Association and the various professional organizations as printed in the foreword of that booklet.

Essentially these principles still depend on understanding action in the local community, with due regard given to the interests of patients, the physician and the hospital. There has been much argument in many hospitals in arriving at a satisfactory answer to this problem. It is tremendously important that boards of trustees and administrators give due regard to fair compensation for the physician. On the other hand, there are many instances in which proper interests of the patient have not been duly protected.

There has been some suggestion that certain of the specialty boards approving residency training might consider requiring certain types of financial arrangements between the hospital and the specialist as a prerequisite to approval. I am sure the leaders in specialty board development are opposed to this system, and, further, there is every reason to believe that it would be illegal under federal antitrust legislation.

While there has been discussion of such a proposal by certain specialty board members, no intention to carry out such a plan has been announced. It is possible, since approval of residencies is to a certain degree a matter of judgment by a board, that such factors would be taken into consideration by a specialty board. If this were done, however, they would certainly be in a very shaky position; in fact, I believe that most people would consider such action against the public interest.

Each hospital must decide on the basis of the three factors mentioned above and, as related to local custom; what is definitely the fair method and amount of compensation. I strongly recommend that where the local board of trustees and administrator are having difficulty deciding on a fair adjustment, outside professional advice from an individual with experience as to practice in hospitals in other communities can be of great assistance.

Fair dealing with the medical staff is extremely important, but equally important is that the board of trustees of the hospital be sure that the patient and the hospital also are fairly treated. — GEORGE BUGBEE.

Courtesy contest

Do you have any literature on the subject of courtesy contests?

The library has a package of the following articles on the subject of courtesy contests:

"Courtesy—A Must in Hospitals." E. Giddings. HOSPITALS, October 1946. 20: 67.

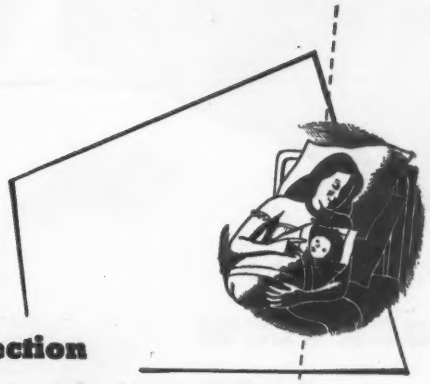
"Contests to Develop Courteous Employees." M. Saunders. HOSPITALS, October 1949. 23: 41-42.

"Courtesy Smooths the Path." G. L. Davis. *Modern Hospital,* March 1946. 66: 72.

"What Kind of an Impression Do Your Employees Make?" A. C. Manry. *Hospital Management,* July 1943. 56: 32.

"Employee-Patient Relations Institute," a play written by Doris L. Gunning, sponsored by the public relations committee of the Rochester General Hospital. 1949. 23 pp.

This package library is available on loan. Requests should be addressed to the Library of the American Hospital Association, Asa S. Bacon Memorial, 18 E. Division Street, Chicago 10. — HELEN V. PRUITT.



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1. Winwell, G. B., Canad, M.A.J., 53:555, 1945.

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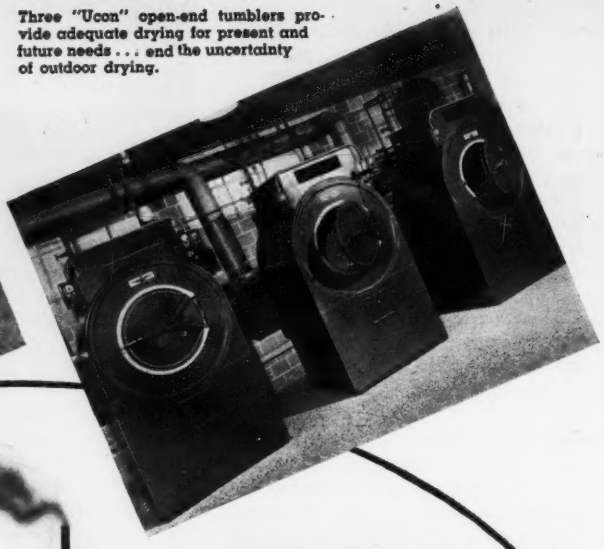

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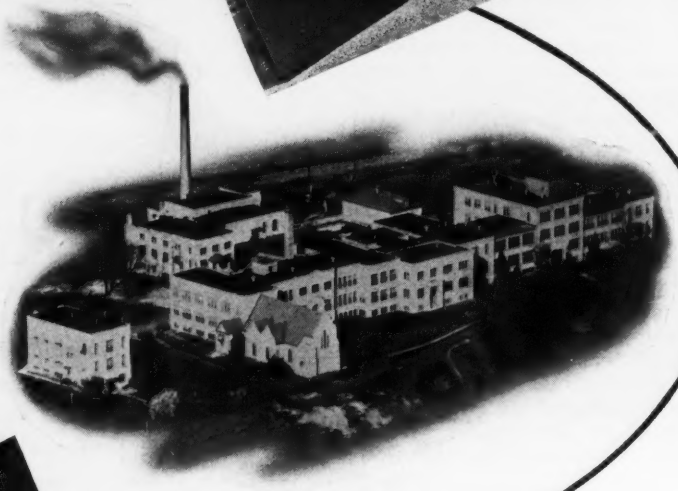

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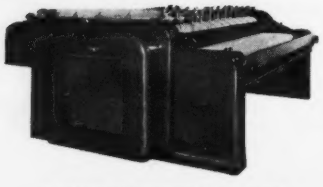

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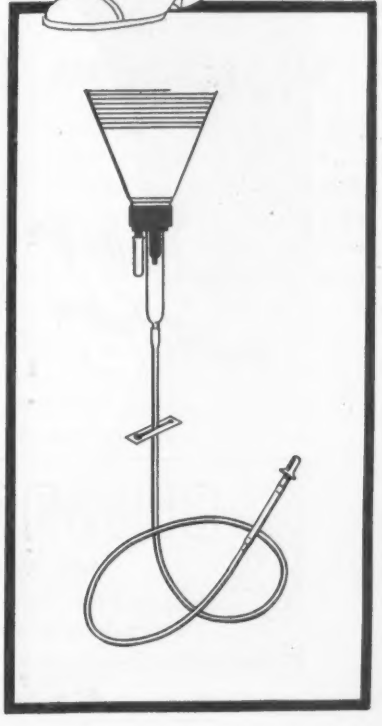
1. Graubard, D. J., and Peterson, M. C. (1949), Intravenous Use of Procaine in the Management of Arthritis, J. Amer. Med. Assn., 141:756, November 12.



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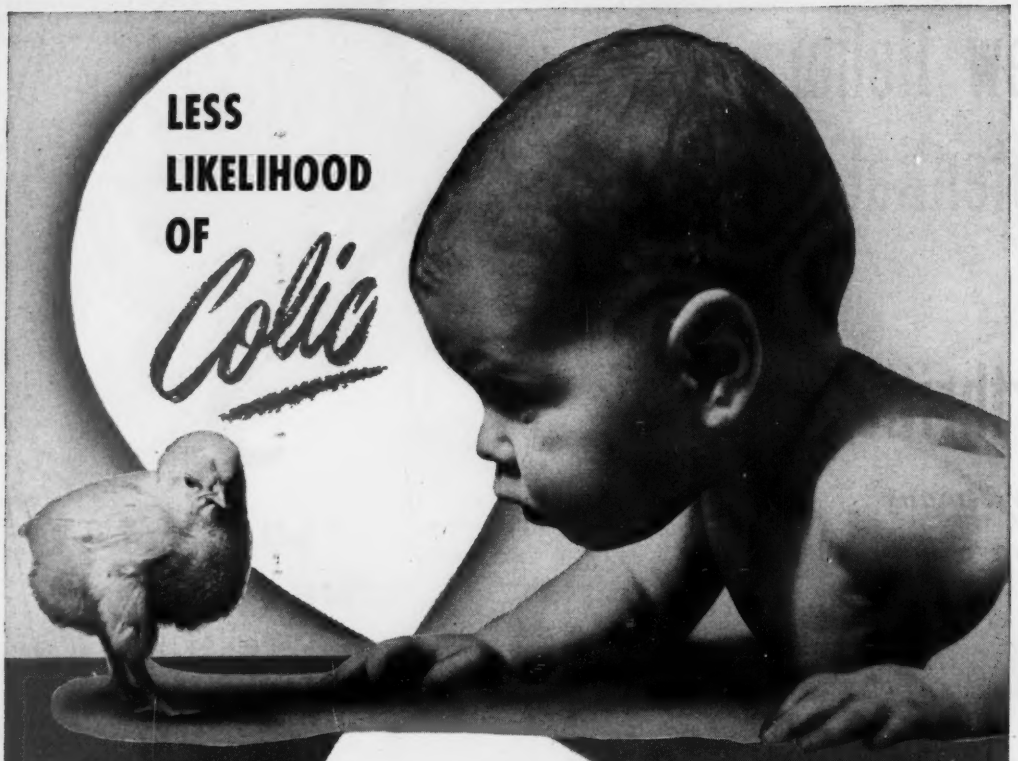

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The issues in federal health legislation

Nearly a dozen major proposals are in the congressional hopper.

ALBERT V. WHITEHALL

CONGRESS WILL NOT act on compulsory health insurance this year. Congress is confused. So are the American people. Compulsory health insurance may be an issue in many local political contests this fall, but recently there have been some indications that it may not even be made a national issue as had been expected earlier.

One reason for confusion is that there have been nearly a dozen other proposals, each based on a different idea. Some of these proposals strive to avoid criticisms offered against compulsory health insurance. Others are attempts to develop a basic principle into workable legislation. Here, outlined in broad strokes, are the various proposals that have been introduced in the Eighty-first Congress.

H.R. 8746. *Sponsored by Representative Wolverton.* This newest proposal, introduced only last month, is in effect the embodyment of an idea presented by Harold Stassen in the *Reader's Digest* for April. The bill would set up a Federal Health Reinsurance Corporation, after the pattern of the Federal Deposit Insurance Corporation, with a three-member board of directors appointed by the President. This reinsurance device is commonly found in the insurance field, and its effect, when applied to the health insurance field, might be quite startling.

By reinsuring the heavier losses for health insurance, Representative Wolverton believes it will be possible for local Blue Cross, Blue Shield and other voluntary plans to give more attractive contracts to subscribers at a reasonable charge. "Within a brief space of time," he said, "this should cover the medical economic problem in the nation." A notable feature is that the government's contact with the program would be confined to the local nonprofit insurance associations. Mr. Wolverton says this bill will largely solve the nation's health problem "without bringing the government into the patient-doctor or patient-hospital relationship."

REPRESENTATIVE WOLVERTON

No more than two of the three members of the proposed Federal Health Reinsurance Corporation could be members of the same political party. Otherwise there are no qualifications for appointment. Initial financing would be by a $50,000,000 treasury appropriation, in exchange for capital stock. Each eligible health insurance plan choosing to participate would pay, in premium charges, 2 per cent of total gross payments received from subscribers. The corporation would pay two-thirds of each claim above $1,000 paid out by the plan for any period of 12 continuous months with respect to any individual subscriber. Prepayment plans, then, would relax contract limitations and offer broader coverage, knowing that the government would assume financial responsibility for two-thirds of the sum spent in excess of $1,000 in catastrophic cases.

Mr. Wolverton, incidentally, is a member of the powerful House Committee on Interstate and Foreign Commerce, and it was he who led opposition to the Hill-Burton Act in 1946.

S. 1679. *Sponsored by Senators Thomas, Murray, Wagner, Pepper, Chavez, Taylor, McGrath and Humphrey and Representatives Dingell and Biemiller.* The current compulsory health insurance bill, now known as the Thomas-Murray-Dingell bill, sometimes is referred to as the Wagner-Murray-

Mr. Whitehall is assistant director of the American Hospital Association and director of the Association's Washington Service Bureau.

REPRESENTATIVE KEATING

—Chase-Statler

REPRESENTATIVE BOSONE

SENATOR HUNT

Dingell bill. It is sometimes called the Truman bill, the Administration bill or the Ewing proposal because of its support by the President and the Federal Security Administrator.

This bill would require simultaneous enactment of a separate tax bill to levy a 3 per cent payroll tax divided equally between employer and employee. These funds would be gathered into a trust fund in Washington. An additional 1 per cent would be put in from the federal treasury. The trust fund would be administered by a National Health Insurance Board of five persons, including the Surgeon General of the Public Health Service and the Commissioner for Social Security. At least one of the five would be required to be a doctor of medicine, which means that the surgeon general might be the only physician on the board.

The National Health Insurance Board would divide the trust fund among the states by careful mathematical formulas based on comparative need, cost of services and other factors. Allocations to the states would be in five main categories: (1) Medical, (2) dental, (3) nursing, (4) hospital and (5) auxiliary services such as drugs, x-rays and false teeth. At this point one authority remarks, "It's easy enough to collect the money by imposing a tax. The hard part is the purchase of service. Solomon himself could not divide those funds to please everybody."

A sincere effort is made to "decentralize" administration. Doctors, hospitals and other participants would agree with such local administration as to methods of payment and other practices which could be determined at the local level. But decentralization would be subject to (1) the amount of funds allocated to states and local areas for purchase of services and (2) federal regulations.

The compulsory health insurance bill makes no provision for indigent persons unless the local communities responsible for them pay premiums into the federal fund. It is generally recognized that the cost of fulfilling the promises made by this program would be stupendous and probably far in excess of estimates, although statisticians in the Federal Security Agency aver that they are immune to the errors that have plagued the British in a similar venture.

S. 1970. *Sponsored by Senators Flanders and Ives and Representatives Herter, Javits, Case, Nixon, Morton, Fulton, Hale and Auchincloss.* This is known as the Flanders-Ives bill. An article in *Fortune* magazine for March reviewed this bill and the compulsory health insurance bill with almost equal enthusiasm. Its sponsors are Republicans sincerely anxious to take a "liberal" viewpoint. Their advisers have patterned the program suggested along the lines of the Health Insurance Plan of Greater New York, which hires its own staff physicians to care for its members and purchases hospital care on a group basis. The Health Insurance Plan was sponsored by the late Mayor LaGuardia, and the majority of its members are city employees.

Loans and grants would be provided to start such small plans in communities and areas all over the nation. Enrollment in these small plans would be voluntary.

—Wide World

MR. STASSEN

SENATOR MURRAY

Premiums would be a percentage of family income.

A national "yardstick" would be established listing all the services that should be rendered by an ideal plan. In each state the state agency and health council would establish a norm. The norm would indicate the cost of providing "yardstick" services in the state. Thus, each community plan providing all the services listed in the national "yardstick" would be entitled to the state-established norm for the services provided to each subscriber. If the subscriber's income were so low that his contributions, based on a percentage of his income, did not reach the norm, the plan would receive a subsidy from state and federal funds.

Administrative provisions in this bill are most complex. At least one commentator has said it would be harder to administer than the compulsory health insurance bill. In this program, as in a compulsory health insurance program, doctors and hospitals would be under pressure to provide their services for prices beyond their control. Not every hospital would be able to provide its usual quality of care at the government-established norm.

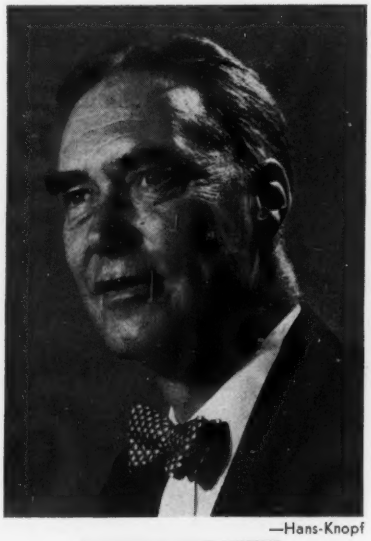
Some proponents of the compulsory health insurance bill believe this to be the next best thing to their own proposal, one reason being that it requires a majority of the members of governing boards of community plans to be persons who do not furnish health services. Although the sponsors of the Flanders-Ives bill believed it would help the Blue Cross plans, it seems that much smaller units are visualized and no means are apparent for preserving the stability that Blue Cross plans have obtained by reason of their coverage of large areas. The Flanders-Ives bill would grant subsidies to make up for differences in income. But an epidemic in a small plan area might throw great strain upon it, where a larger plan like Blue Cross would spread this risk over a larger area.

S. 1805. *Sponsored by Senator Humphrey.* Probably at the request of cooperative groups, Senator Humphrey introduced a bill to provide for loans to cooperatives wishing to establish their own programs of purchasing medical and hospital services. Brief hearings have been held by the Senate Committee on Labor and Public Welfare, but the bill has not attracted wide attention beyond cooperative groups and organized medicine.

S. 1106. *Sponsored by Senator Lodge.* In the Eightieth Congress and again in the Eighty-first, Senator Lodge has proposed that the federal government should pay half the cost of state programs to provide "certain medical services and medicines, which are standardized in their nature but which, because of their high costs, are not used in many cases in which their use in desirable." Medical aid would include x-ray, laboratory, diagnostic services, respirators and drugs. The state would be required to participate financially, and the Surgeon General of the Public Health Service would allocate federal funds on the basis of demonstrated need.

To those who believe that the distribution of health services can be solved by making health care less expensive, "across the board," this bill has had considerable appeal.

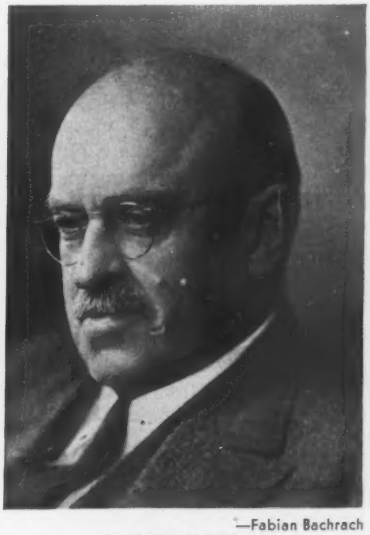
S. 2940. *Sponsored by Senator*



—Hans-Knopf

REPRESENTATIVE HERTER

SENATOR HILL



—Fabian Bachrach

SENATOR FLANDERS

Hunt. Senator Hunt of Wyoming is a dentist who believes that his professional colleagues must be more liberal in their approach to federal participation in the distribution of health services. His concept is a voluntary health insurance plan operated by the federal government to pay all health care expenses over $5 per year for families with incomes under $5,000. But while the bill goes into detail on services to be provided, it is practically silent on the most vexing problems in all such legislation—financing and administration. Premiums and policies are to be established by a National Health Insurance Board of five members including the Surgeon General of the Public Health Service, who would also represent the medical profession; representatives of hospital and dental associations, and two representatives of the general public. The entire responsibility for subscription charges, benefits and administration is handed over to this board without being spelled out.

Senator Hunt's bill would also establish a Department of Health, grouping all of the present health functions of the federal government under it. He has a provision for special aid for developing health services in rural and shortage areas and a section offering assistance to experimental health cooperatives.

INDIGENT CARE

S. 1581. *Sponsored by Senators Taft, Smith and Donnell.* The Taft bill in the Eightieth Congress was the first counter-proposal. S. 1581 in the Eighty-first Congress is much like S. 545 in the Eightieth, but with some improvements and simplification. Briefly, it proposes federal grants-in-aid to state-devised programs to make medical, dental and hospital care available to persons unable to pay the whole cost. Senator Taft does not specify a method. Indeed he once said, "I suppose my bill would help a state program of compulsory health insurance if the state wants it. But that is for the state to decide. The federal government should not impose an arbitrary pattern."

The Taft bill also offers general assistance (up to 25 per cent of the cost of the state program) for development of voluntary nonprofit health insurance plans, establishment and staffing of diagnostic facilities, and inducements to physicians and dentists to practice in low income areas.

—Baker

SENATOR TAFT

—Ryan

SENATOR HUMPHREY

—Harris & Ewing

SENATOR THOMAS

S. 1456. *Sponsored by Senators Hill, O'Conor, Withers, Aiken and Morse.* The Hill bill, called the Voluntary Health Insurance bill, is supported by the American Hospital Association. It aims to encourage all of our self-supporting people to use voluntary health insurance, such as Blue Cross, for protection against the emergency cost of illness. It would require federal and state governments to permit payroll deductions for employees wishing to enroll in nonprofit prepayment plans. It would assist states in programs to discover how the government might assist in extending voluntary health insurance rather than trying to undermine it.

Persons unable to pay subscription charges for voluntary prepayment plans would be provided unidentifiable cards or certificates, which would entitle them to the same care as self-supporting citizens. Claims under these cards would be identified only by contract number, and the cost of such care would be borne by the federally assisted state program. The assistance aspect of the program would receive the usual careful supervision by government agencies. But the voluntary health insurance program for the great majority of self-supporting people would be left entirely free of regulation and would be stimulated toward fullest possible expansion.

The Hill bill also provides: (1) Payment of nonprofit health insurance premiums during periods of unemployment; (2) surveys of existing diagnostic facilities; (3) surveys of existing facilities, services and financing of long-term care; (4) surveys of areas unable to attract doctors and dentists because of low income; and (5) surveys of existing enrollment in voluntary prepayment plans. From these surveys the states might well be able to take steps for further improvement of the distribution of health services without requir-

(Continued on page 60)

A camera in the nursery

HAROLD P. ALDEN AND EDWARD C. DeLEAR

PHOTOGRAPHIC RECORDS of children, showing their development from one period to the next, have long been the favorite device of fond parents. Usually missing from this record, however, is a picture of the child soon after birth. Some fathers have tried to capture this moment by aiming a camera through the window of the nursery or by hiring a photographer to take a picture from the same angle. This method, though, often produced a good picture of only the nurse who held the baby. This problem was solved at St. Francis Hospital, San Francisco, with the introduction of special equipment.

The administrator of St. Francis was approached by Carl Dial, a former photography instructor and present owner of a photo studio, who offered a unique solution. He had developed a high-speed automatic camera that would photograph babies lying in their cribs, thus eliminating one of the greatest obstacles. The remaining problems of sterile technique, the nursing work load and safety standards were attacked jointly by Mr. Dial and the hospital staff.

Violation of sterile technique procedure was largely overcome by the extraordinary features of the equipment itself. The camera is entirely electrical. A motor moves the film after each picture is taken. Reloading is necessary only after 325 exposures and is effected readily by means of a detachable film cartridge. The photographer wears a sanitary gown and mask during his short visit to the nursery. To obviate the necessity of the nurse's touching a switch with her sterilized hands, a foot button was installed so that pressure of the foot turns on the equipment and another touch takes the picture. The camera shuts off automatically after a brief period.

Because of the nurse shortage, it was considered essential that nursery routine be disturbed as little as possible. Original plans for having the crib wheeled or carried to the camera therefore were discarded. The new procedure of photographing was incorporated with existing routine — examination of the two-day-old infant by the resident physician. This examination is made on a small table in the nursery. A pre-focused camera is permanently mounted above the table at which it is aimed. The name of the baby is written with wax pencil on the examining table for identification purposes. This and the application of pressure on the foot button control are the only additional duties of the nurse.

The lens of the camera is located slightly more than four feet from the baby. The stroboscopic bulb is covered to safeguard the baby against the remote possibility of breakage. An authorization form is presented to each mother before the photograph is taken. This, however, presents no problem, as reaction has been enthusiastic.

A photograph of her new baby is presented to the mother without charge before she leaves the hospital. At that time she is given information regarding the purchase of extra prints from the photographer. Attractive pink or blue diaper-shaped birth announcements, in which the baby's picture is centered, are available at low cost.

In the short time since its inception, this new service has proved a tremendous success at St. Francis Hospital from the public relations standpoint. While it is still in the experimental stage, it is believed that the plan eventually will be on a financially sound basis. At that time any income available to the hospital from this source will be devoted to maternity beds for medically indigent mothers.

CAMERA for photographing newborn babies is set up above examination table in nursery.

Mr. De Lear is assistant administrator and Mr. Alden is administrative resident of St. Francis Hospital, San Francisco.

PICTURE of newborn baby and other pertinent data are shown in diaper-shaped birth announcement, with safety pin fastener and space for addressing and stamp on outside.

From the admitting office . . .

to the hospital laboratory . . .

Chest x-rays plus routine laboratory examinations

JAMES S. FARRANT

A STREAMLINED PROCEDURE for handling routine chest x-rays and laboratory examinations has greatly improved the efficiency of post-admitting-time operations at the 266-bed Genesee Hospital in Rochester, N. Y.

Our hospital, like others in New York State, has taken advantage of the state's offer to install miniature x-ray machines for routine chest examinations. In this program, the state pays for and installs the necessary equipment and provides 50 cents for each patient x-rayed to cover operating expenses.

Capitalizing on this assistance, we have combined chest x-ray examinations with routine laboratory examinations so that these operations now are handled immediately after the patient is admitted, in all but a few instances.

The miniature chest x-rays were introduced in three stages. The first stage was inauguration of chest x-rays for all inpatients and integration of x-rays with laboratory examinations. Approximately 90 per cent of the patients admitted to the hospital now receive chest examinations, and they have become the rule for all hospital employees, including students in the nursing school. (Even greater coverage would be achieved were it not that tonsils and adenoids cases are omitted—for obvious reasons—and that the state has limited the taking of routine x-rays to admitted patients who are 15 or more years old.)

Mr. Farrant is administrative assistant of the Genesee Hospital, Rochester, N. Y.

The second stage saw the initiation of routine chest x-rays for all obstetrical patients, and in the last stage, work was begun to provide the same service for outpatients.

COST OF PROGRAM

Costs to the hospital for the addition of the chest x-ray program were limited to expenditures necessary in preparation of the examination room (cleaning, painting, an electric sign) and the cost of the films (seven cents apiece).

Additional personnel were not needed since the increased work was absorbed by existing employees and volunteer workers. The latter group consists largely of volunteer Red Cross workers, known as "gray ladies." It was necessary, however, that the heads of the radiology and pathology departments revise their employee work schedules so that coverage could be obtained.

In hospitals less fortunate than ours, it probably would be necessary to purchase the x-ray unit, provide an additional small room to take the chest x-rays, install a private lavatory for obtaining urine specimens, and obtain the part-time or fulltime services of an additional laboratory or x-ray technician.

An estimated breakdown of costs for the above would be as follows:

Miniature x-ray unit (22 milliamperes, single tube)	$ 11,500
Chest x-ray room (10 x 14 x 10 ft., concrete construction built in existing area)	$ 350
Lavatory unit	$ 650

While combining these two procedures, Genesee Hospital also developed a new and better system for handling admissions.

X-ray technician .....$1.25/hr.
Laboratory technician .....$ .98/hr.

DETAILS OF PROCEDURE

In combining routine miniature chest x-rays with routine laboratory examinations, we have worked out a new procedure to be followed after patients are admitted. This procedure has proved to be a great saving in time and energy since it reduces floor visits of laboratory technicians to a minimum. A breakdown of the steps is as follows:

Surgical admissions: Patients admitted for surgery are taken directly from the admitting office to the laboratory by one of two gray ladies assigned to this duty during regular admitting hours (1:30 P.M. to 4:30 P.M. daily except Saturdays).

Upon arrival at the laboratory, the gray lady presents the admitting office identification slip to the laboratory technician. This slip identifies the patient and gives instructions as to the work to be done. Examinations are performed by technicians assigned exclusively to this work during admitting hours.

If the technician is unable to obtain a urine specimen at this time, a 3 x 4-inch pink cardboard ticket is stamped with the words "Urine specimen needed." This ticket is then given to the gray lady, and, provided the rest of the examination is complete, she accompanies the patient to the chest x-ray room where the procedure is repeated with another identification slip.

After the x-ray has been made, the gray lady accompanies the patient to his quarters. She, in turn, goes immediately to the nursing station supervisor, reports the arrival of the patient, and gives to her the patient's admission card and the pink cardboard ticket (whenever one has been found necessary). The gray lady is then free to return to the admitting office to start out with another patient.

Medical admissions: The post-admitting-time procedure for medical patients is the same as that for surgical patients except that the trip to the laboratory is omitted. Such patients are taken directly to the chest x-ray room.

The admitting officer accumulates the laboratory slips for these patients and in the afternoon sends them via messenger to the chief of laboratory service. The latter then assigns a technician to do the required work when she is making her daily rounds the following day. (Medical patients are a decided minority, since more than 65 per cent of all admissions are surgical patients.)

Procedure outside of admitting hours: For house admissions between 4:30 P.M. and midnight, the admitting officer telephones an x-ray technician who is on call, accompanies the patient to the x-ray room for examination, and then conducts him to the floor. The intern is responsible for seeing that urine and blood samples reach the laboratory with the least possible delay.

When morning admissions occur, from 8 A.M. to 1:30 P.M., the admitting officer informs the laboratory (if the patient is a surgical case) and assigns a member of his staff to accompany the patient. He also telephones the x-ray office (for both medical and surgical patients) and notifies the secretary that a patient will be down.

Laboratory samples and chest x-rays for admissions from midnight until 8 A.M. are processed the following morning.

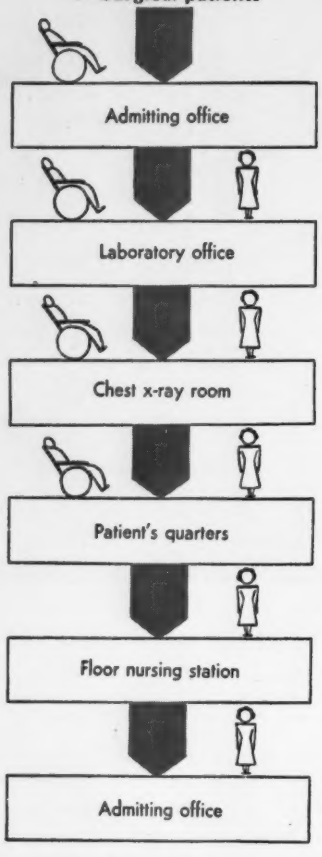
Emergency room admissions: For admissions made through the emergency room, it is the responsibility of the nursing supervisor of that division to see that chest x-rays are taken. She provides the technician with the patient's name, ad-

to the chest x-ray room . . .

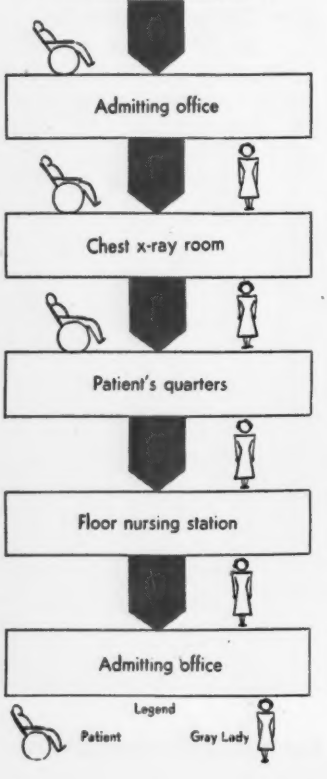
to the patient's quarters.

Flow chart

1—Surgical patients



2—Medical patients



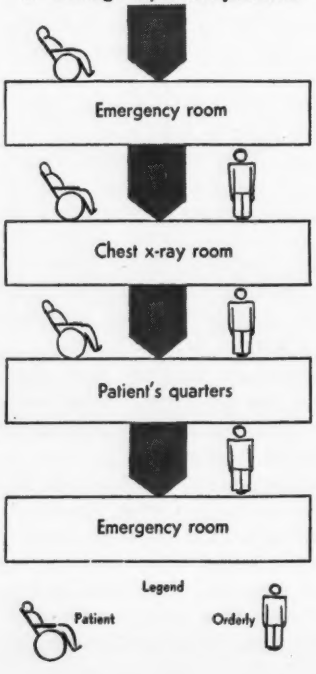
dress, and quarters assignment. Since the chest x-ray room is adjacent to the emergency room, we make a special point of trying to get chest x-rays on all emergency admissions before sending them to the floors. We purchased a $1,230 x-ray table for the chest x-ray room so that major x-ray work may be done there when necessary. This is especially advantageous for emergency patients.

Obstetrical patients: Some of our obstetrical patients began their weekly visits to the clinic before our chest x-ray program was inaugurated. We have been clearing up the backlog by scheduling five to eight of them for x-rays every Monday.

New obstetrical patients are scheduled for x-rays at their initial appearance in the clinic. Each is directed to the x-ray room, where she presents her identification card to the technician. When the x-ray has been made, the film, together with the radiologist's report, is returned to the clinic and filed with the records there.

Private patients of staff physicians also are given attention by the technician. The reports of these examinations are sent from the x-ray office to the obstetrical department, where they are filed alphabetically until the patients arrive, at which time the reports are placed in their records. The staff physician may inspect this file whenever he desires.

3—Emergency room patients



Outpatients: Chest x-ray technicians have been processing 10 to 12 outpatients daily between 9 and 10 A.M. The outpatient department has been following a plan similar to that of the obstetrical clinic. New patients are sent routinely to the x-ray room for chest x-rays, and the backlog of old patients who have not had x-rays is gradually being assimilated on return visits.

SPECIAL CONSIDERATIONS

For patients who are nonambulatory but otherwise strong enough to make the routine visits, a gray lady is assigned to take them by wheel chair to the laboratory, the chest x-ray room, and to the floor.

Patients unable to make the rounds are taken directly to the floor. The admitting office then informs the director of laboratories of the new admission and requests that a laboratory technician be sent immediately to the patient's quarters for blood and urine samples. X-ray scheduling is handled by a technician, who visits the respective floors each morning. He distributes slips made up by the admitting office for patients who should be sent before 10 A.M. to the chest x-ray room for plates. Patients are taken to the x-ray room by nursing personnel as soon as they are able to be moved safely.

In cases where a patient is admitted within six months of a previous admission, the routine chest x-ray is waived. Knowledge of the previous x-ray is the responsibility of the admitting office. Laboratory work, however, is to be performed as usual.

When active or suspected tuberculosis is found, a large chest x-ray is taken to determine the extent of the infection.

Reports on chest examinations are made to the local health bureau by the x-ray office on forms supplied by the New York State Department of Health. These forms are filled out in duplicate. The originals are sent to the health bureau and the copies are filed in the x-ray office.

This hospital seeks new employees by selling itself to those who advise high school students about job opportunities.

Recruiting workers through school guidance counselors

EDWARD E. JAMES

TO THOSE OF US in the hospital field, recurring shortages of trained people are a familiar story. We tend even to accept the situation and assume that everyone else realizes that shortages exist.

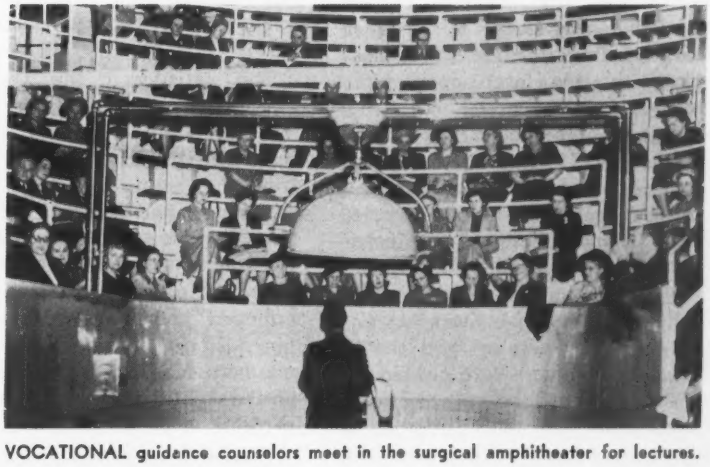
In schoolroom discussions of hospital opportunities with vocational guidance counselors, representatives of the Pennsylvania Hospital were amazed to find very inadequate knowledge of hospital careers. Often counselors, the persons directly responsible for channeling large numbers of high school students into vocational fields, had little if any accurate information at hand for their own guidance. Frequently their only knowledge of hospital occupations was of their disadvantages.

An indication of attitudes was in the frank surprise with which counselors sometimes received enthusiastic accounts of the advantages of hospital work. "Why," they would say, "that doesn't sound bad at all." Often representatives would be asked by unbelieving teachers, who apparently thought only old fogies worked in hospitals, "How did *you* ever get into hospital work . . .?" It was clear that an information program for vocation guidance counselors was needed.

Various ways to provide counselors with accurate hospital career information were discussed. A number of plans, ranging from a scheduled tour by representatives of each occupational field down to mere distribution of mimeographed data, seemed feasible. At length, however, it was agreed that the educators, unfamiliar with the atmosphere and work pace of an institution geared to the care of the sick, could learn more about hospital careers by spending a day in a hospital than in any other way. Important savings of time for key hospital personnel and an opportunity for personal contact with the teachers proved important advantages.

Mrs. Mildred Brown, registrar of the school of nursing, whose suggestion touched off the career workshop planning, was appointed workshop chairman. From her long experience with the Pennsylvania Hospital's nursing information program—a project to provide high school students with objective up-to-date data on nursing as a profession — Mrs. Brown had learned the inadequacies of medical field information available to counselors. A tentative program designed to fit the needs of the teachers was worked up, and various members of the hospital professional staffs were contacted. Although considerable extra work by already busy people was involved, the idea was greeted with great enthusiasm, and many constructive suggestions were offered. Invitations were sent to guidance counselors throughout the Philadelphia area, many of whom already had expressed to Mrs. Brown their interest in participating in such a program.

It was decided to emphasize the present, as well as the future, opportunities of the hospital field. This the workshop planners defined as the "outlook" for hospital occupation. To present the outlook to guidance counselors, two speakers were invited to open the morning workshop session. John N. Hatfield, president of the American Hospital Association and administrator of the Pennsylvania Hospital, spoke on "The Hospital Outlook." Dr. Roy B. Hackman, director of the department of counseling and guidance at Temple University, discussed "The Occupational Outlook." With the scope of the field established for the counselors, it was proposed that their attention then should be directed toward specific hospital occupations. This was to be the "look-in," as contrasted with the



VOCATIONAL guidance counselors meet in the surgical amphitheater for lectures.

Mr. James is assistant administrator, Pennsylvania Hospital, Philadelphia.

"outlook," phase of the program.

Because of the great amount of material to be included and the need for accuracy, a symposium was considered to be the best presentation method. Twelve general fields, to be covered by 20 speakers, were included. These fields and the persons who spoke are as follows:

Medicine, general—internist.

Medicine, specialties—surgeon.

Nursing, for women — director, school of nursing.

Nursing, for men — director, school of nursing for men.

Personnel administration — employee relations manager.

Hospital administration, purchasing and engineering—administrative assistant.

Accounting—comptroller.

Medical social service—director, social service department, and supervisor of public health nursing.

Nursing education—dean, school of nursing, University of Pennsylvania.

Nursing administration — assistant director, school of nursing.

Counseling—counselor and psychologist, school of nursing.

Technology, x-ray—director, department of radiology.

Technology, laboratory — director of laboratories.

Library service, medical records —director, medical record library.

Library service, medical reference—two of the hospital's staff librarians.

Dietetics—dietetics instructor.

Hospital administration, general —assistant administrator.

PROGRAM IN AMPHITHEATER

The morning program of the workshop was staged in the older surgical amphitheater of the hospital. In this large open room teachers were exposed to the atmosphere of a modern hospital and saw some of the sights and heard many of its peculiar sounds. Nurses in surgical gowns often hurried past an open door, and the insistent tones of a call system penetrated the amphitheater. Hospital schedules were not altered in any way. Guests were warned that if the amphitheater were needed the meeting would be moved to an auditorium. A short briefing in fire emergency procedure was given before the session formally opened.

After lunch in the hospital cafeteria, the vocational counselors each attended three discussion meetings, held in three different rooms in the hospital buildings. Counselors were assigned to one of the groups, and the groups then moved between meeting places. By moving about the buildings, the counselors gained additional impressions of hospital operations.

Each group was small enough to permit reasonably free discussion. Each symposium speaker, assigned to the medical occupations, administrative occupations, or educational occupations group, met with the teachers to answer questions. Invitations were extended the counselors to visit any hospital departments they cared to. By that time most had had their fill of hospitals for one day and were content merely to sit and talk about the various departments. Several made appointments, however, to return with groups of students for department tours at a later date.

OPEN HOUSE

An open house, held in a nurses' residence, ended the workshop program. Symposium speakers again attended, last minute questions were answered, and additional dates for student visits to the hospital were made.

Seventy-four vocational guidance counselors attended, representing 13 counties in three states. Each counselor came in the interests of at least 100 pupils from his school, so a minimum of 7,400 pupils now in high school may be influenced by the workshop program.

The statistics of the workshop are not the most gratifying aspect for those who worked for its success. The basic satisfaction came from the feeling that some counselors now had accurate information about hospital occupations to pass on to their students. Sincere letters of thanks from many who attended and numerous requests for a similar program made the planners feel that they had been on the right track in suggesting the project.

Although we considered the program an unqualified success, we followed up by sending out questionnaires to all teachers who had been present, asking their opinions and requesting suggestions for workshop improvement. The returns, unsigned at our request, were almost entirely favorable. The prevailing criticism was that the hospital had planned too full a day for the counselors and had tired them out. That criticism doubtless was a valid one, for by the end of the day hospital staff members connected with the program also were exhausted.

DETAILS OF PLANNING

This account of the workshop may be misleading, for it merely suggests the great amount of detailed planning that started weeks before the program date. Proper timing of symposium discussions was a major requirement. Guides had to be furnished to lead counselors from place to place. Traffic control, especially in the surgical area, was a problem. Nearby lavatory facilities were inadequate. Hats and coats had to be checked somewhere. A central registration and information desk was a necessity. Minor but important details such as identification tags could not be overlooked. Above all, a large and enthusiastic group of co-workers was required to make the workshop a success.

Despite its complexity and the drain on the time and energies of busy people involved in its staging, the workshop on hospital careers is considered to have been worthwhile. Counselors were given accurate recent career data and an idea of the working conditions, atmosphere and pace of a modern hospital. They were made to see the challenge of hospital employment and the enthusiasm that hospital people have about their choice of work. For their part, hospital staff members enjoyed playing host to the vocational counselors and learned from the questions put to them. All felt that, even if not a single pupil embarked this year on a hospital career as a result of the workshop, the day had brought nearer that public understanding and appreciation of hospital performance that all hospitals desire.

Aimed primarily at smaller hospitals, the new book sets forth principles and patterns that are applicable to all.

Manual on nursing service will promote uniformity

EDWIN L. HARMON, M.D.

HOSPITAL ADMINISTRATORS, nursing service and school directors, students in these fields, hospital board members and nursing school committees will profit from careful study and usage of the recently issued "Hospital Nursing Service Manual."

Prepared under the joint auspices of a committee of the American Hospital Association and the National League of Nursing Education, with collaboration by representatives of the American College of Surgeons, the American Medical Association and the American Nurses' Association, the manual is published by and available through the offices of the National League of Nursing Education, 1790 Broadway, New York 19.*

The manual in a sense both revises and replaces the earlier "Manual of the Essentials of Good Hospital Nursing Service." It embraces a wider scope than that of its predecessor. It is, in fact, "a new manual which emphasizes principles of good hospital nursing service and which may be used as a guide by nursing and hospital administrators and by governing boards of hospitals in determining good practice in their own institutions," according to its preface.

Although the preface states that the book is intended primarily for the smaller hospital, the principles set forth and the basic patterns and content are entirely applicable to all hospital nursing services. It is unique in its simplicity. Its comprehensive portrayal of basic framework and principles, however, is such that, suitably adapted to hospitals of varying types and size, it will be a valuable guide to sound hospital nursing organization and practice in every environment.

The introduction and first three of the nine sections place and relate the nursing department to the hospital as a whole in its broadest functions, community responsibilities and relationships. Its subsequent sections contain both principles and detail sufficient to guide those responsible in essentially all phases of intra-nursing and interdepartmental function and relationship. Of particular interest and value should be the sections on organization; administrative policies and measures for providing nursing service; personnel practices, and departmental budget and cost accounting.

Some will regard the manual as rudimentary, and others will be disappointed to find that it is not an encyclopedic procedure manual to serve as a ready reference source on how to set up, staff and operate a central supply room or an infant formula room or to detail the handling of infectious cases. Within those two extremes lies its value. Many references to more elaborate portrayals of detailed subjects are contained at the end, appropriately annotated to subject content of the body of the manual.

The committee responsible for the manual purposely avoided producing a voluminous compendium of detailed procedure methods in the belief that such information is readily available in other published material and that this manual should concern itself with patterns and principles, with only illustrative detail sufficient to portray methods.

The manual is not arbitrary and dogmatic in its approach. It refrains from using the word *must* and states instead that the good nursing service *will* or *should*, thereby wisely recognizing the diverse factors that may prevent the achievement of the ideal in the individual hospital environment except through progress as it may be evolved. This quality of the manual should appeal especially to those on the firing line of making ends meet.

The sponsoring organizations are to be commended for this exceedingly valuable, practical and usable manual. The harassed hospital administrator and distraught nursing director will by no means find the complete solution to their problems within its covers. They would be well on their way to such solutions, however, in a hospital with an effectively operating nursing service embodying the principles and philosophy of this manual.

If hospital and nursing administrations will accept and follow the

Dr. Harmon is director of Grasslands Hospital, Valhalla, N. Y.

*Copies of this joint manual of the American Hospital Association and the National League of Nursing Education have been distributed without charge to all institutional members of the Association.

Committee members

Members of the committee that prepared the "Hospital Nursing Service Manual" were: Chairman, Mildred I. Lorentz, R. N.; representing the American Hospital Association, E. L. Harmon, M.D., F. Stanley Howe, Herbert M. Wortman, M.D., and, *ex officio*, George Bugbee and Charles T. Dolezal, M.D.; representing the National League of Nursing Education, Clare Dennison, R.N., Laura M. Grant, R.N., Mildred I. Lorentz, R.N., Blanche Pfefferkorn, R.N., Ruth Sleeper, R.N., and, *ex officio*, Agnes Gelinas, R.N., and Adelaide A. Mayo, R.N.; representing the American College of Surgeons, Malcolm T. MacEachern, M.D.; representing the American Medical Association, Thomas P. Murdock, M.D.; and representing the American Nurses' Association, Emily C. Cardew, R.N.

Actual writing of the manual was done by Stella Goostray, R.N., and Miss Pfefferkorn.

patterns and principles of the manual as a common practical guide and not regard it as just another publication to be put on the shelf as "interesting but too idealistic for my hospital at present," it will serve as an important medium toward resolving the nation-wide confusion and differences on the hospital nursing problem.

An analogy may be drawn from another hospital area of important concern to all. Although manuals of hospital accounting are now in common use, hospitals are still suffering the penalties of their failure to have started earlier and to have progressed more rapidly in the effective usage of reasonably uniform accounting methods.

Those responsible for administering welfare and government funds, although recognizing and sympathetic to the many variables in individual hospital cost elements, have held quite properly that the basic patterns for determining those costs should follow more uniform methods. This failure has been an important deterrent in the development of more adequate Blue Cross reimbursement rates to hospitals.

Despite the many exceedingly confusing and difficult elements of the hospital nursing problem of the last decade, there is an issue confronting hospital nursing departments that is analogous to that of accounting. Nursing service, comprising so large and important a segment of the total operating costs, has also a definite relationship to the over-all financial picture of the hospital.

No one has the answer, for example, as to what the ideal number of nursing hours per patient-day in a given type of service should be or the ideal ratio of graduate nurses to that of auxiliary workers. Many have found an average of 3.5 hours of general nursing per surgical patient-day impossible of achievement and regard it as unnecessarily high. Regardless of that, it is of the utmost importance that we seriously study the subject, with far greater uniformity of method, so that we may evolve acceptable ratio spreads and progress toward the narrowing of the wide gap that exists in actual performance among individual hospitals. By so doing, hospitals will be able to show to a greater extent—and satisfy the public that supports them—that common denominators of service are emerging based on supportable facts and not on emotion.

This, in turn, should have great significance in the hospital's financial operation and in improved community relationships, as well as in better nursing care for the patients.

The nursing hour per patient ratio subject has been used here merely as an illustration. There are many other points of equal importance in hospital nursing service and education on which we have by no means achieved uniformity of thinking or performance. On some we probably never shall. That is wholesome, if not overdone, as it will mean growth with changed conditions.

Nevertheless, despite the great progress hospitals have made and are making on all fronts, the informed observer will agree that there is still great room for improvement. An important medium for achieving that improvement will be intelligent self-appraisal and study and adherence to proved principles and common methods of performance and self-study.

The new manual provides the framework for both, written by individuals with wide and sound experience in the field. It should be accorded the reception it deserves and considered for what it is: A practical working guide toward improved organization and performance of the diversified nursing service and teaching functions within our nation's hospitals. So used, it can serve as a medium that may well have far-reaching significance in the hospital field quite beyond its direct potentialities in nursing.

ONE FOR THE RECORD

For sale—cheap

AUCTION SALES produce real bargains sometimes, and a young couple in Downey, Idaho, amateur real estate dealers, have legal documents to prove it.

Early in April, James L. Pool noticed a particularly choice site of 28 lots, almost an entire city block, advertised to be auctioned off at a public tax sale. On the day of the sale, bidding was not too spirited. Mr. Pool and his wife put in the top price for the lot, paid $411.29, and considered the transaction legally concluded.

It was, even after someone discovered the county's recently constructed $100,000 Marsh Valley Hospital occupied the 28 lots. Mr. and Mrs. Pool were legally the new owners of the hospital too.

City and county officials attempted to rectify the gross mistake quietly. They checked and rechecked, but the sale had been completed, approved and recorded. Then they approached the new hospital owners and suggested buying back the property—at *less* than the $411.29 purchase price. That didn't work.

About this time, local papers learned of the situation and carried news of the auctioned hospital. Downey residents were horrified that the product of many years' planning and several fund-raising drives had been sold for $411.29.

City officials again called on Mr. Pool, offering to buy back the property at purchase price. The Pools, who had no intention of getting away with anything, agreed, and the second sale was duly recorded. Said Mr. Pool, "We feel that we have just donated $100,000 to Bannock county taxpayers."

Any good anecdote is one for the record. Share yours by sending it to "One for the Record," editorial department of HOSPITALS, *18 E. Division St., Chicago 10.*

Setting up a postoperative recovery room

L. L. WEISSMILLER, M.D.

IN THE PAST few years, persons concerned with the care of postoperative patients have become increasingly aware of the need for specially equipped rooms to provide adequate patient care during this critical phase of hospitalization.

At the 216-bed Foundation Hospital in New Orleans we have installed a postoperative recovery room and have been enjoying its benefits now for the past three years. A review of the lessons that we have learned may prove helpful to others who are considering a similar installation.

Fundamental to the success of a postoperative recovery room is proper positioning in respect to the operating rooms. The recovery room should be adjacent to the operating rooms, and if possible it should be connected with them by a corridor not open to public traffic. This permits rapid and private transfer of the patient from one facility to the other and makes an anesthesiologist's services easily available in an emergency. Doors and corridors should be sufficiently wide to permit the patient's bed to be brought into the operating room. This eliminates the necessity of transfer to and from a wheeled litter. The recovery room also should connect with a hospital corridor in order that the patient may be transferred to his own room without interfering with surgery.

It is most important that all patients be visible from any place within the recovery room. Consequently, the room should amount to little more than a shell, with no cubicle partitions or other visual obstructions. Cubicle curtains on wires or rods are desirable to permit temporary privacy, but ordinarily they should not be drawn. Only a minimal amount of segregation of the sexes is necessary, and this may be provided by dividing the room into two sections by means of partial partitions with windows. Beds should be placed parallel, with the heads toward the windows, and should be equipped with side rails. Eighty-six square feet per bed provides adequate space for patient care and traffic without crowding. If space is at a premium, 66 square feet will do. Rubber tile floor covering is advantageous, since it reduces noise and is easy to keep clean. Venetian blinds are more satisfactory than conventional window shades.

NUMBER OF BEDS NEEDED

The number of recovery beds required by a hospital depends upon the number of postoperative patients sent to such a room and the average time spent there. The consensus seems to be that one recovery bed for each operating room is adequate and that the time spent in recovery approximates that spent in surgery, varying from 15 minutes to five hours, for an average of one to two hours. These figures are undoubtedly a fair reflection of the use of the recovery room in the average general hospital.

Foundation Hospital is not a typical hospital in many respects. Many of its routines and statistics, therefore, are also atypical. It appears to be the usual practice in most hospitals, for instance, to offer this specialized care only to those patients who are unconscious, in generally poor condition, have high spinal blocks, or are receiving blood transfusions. We routinely send to the recovery division all patients who have had general (including intravenous and rectal) and spinal anesthesia; also those requiring close observation who have had only local anesthesia. As a result, we may handle as many as 25 patients in one day.

Since most of our patients are referred by physicians outside the hospital, a high proportion of the surgery is long and complicated. Operations often require many hours, and such patients require close observation for long periods. Thus patients are kept in our recovery division from one hour to several days. The average stay is approximately 12 hours.

Instead of the recommended ratio of one recovery bed per operating room, we have 15 beds and

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Dr. Weissmiller is director of the Foundation Hospital of the Alton Ochsner Medical Foundation, New Orleans. Adapted from a paper presented at the sectional meeting of the American College of Surgeons (Hospital Section), Belleair, Fla., January 1950.

Recovery rooms contribute to better patient care

IT IS GENERALLY conceded that most surgical procedures are now relatively safe. No longer does the physician fear subjecting a patient to an operation of almost any magnitude. The necessity of competent anesthesia for the safe performance of surgical procedures is also generally accepted. Unfortunately, not enough attention has been paid to the need for adequate nursing care during the period immediately after an operation.

No surgeon would consider requesting from the nurses' registry a special nurse to assist him in an operation. Instead he insists upon a nurse who is especially trained as a surgical nurse — *a specialized nurse*. Specialized nursing for immediate postoperative care is even more essential. More complications develop postoperatively because of the lack of specialized nursing than would occur if other than a surgical nurse were to be used in the operating room. Also, in the operating room the surgeon is present and can handle any contingency that may arise—in the immediate postoperative period he is usually absent. Thus it is vital that the patient be cared for by a specially trained individual.

Such a nurse must be able to detect *early* evidence of respiratory embarrassment. She should know how to correct it by urging the patient to cough or by aspirating the trachea; and she should recognize the need for operative procedures such as bronchoscopy or tracheotomy. Complete anoxia of only a few seconds is not compatible with life. The ability to detect incipient changes in a patient's general condition and to evaluate these changes make it possible for corrective measures to be instituted before irreparable damage is done.

When the Foundation Hospital in New Orleans was opened, it was obvious that because of the highly complicated cases referred to it, specialized care in the immediate postoperative period was necessary. A recovery room was established accordingly.

In this room it is far easier to observe all the patients than if they were in individual rooms or cubicles. Because all patients recently operated upon are confined there, it is possible for the staff to make rounds on and observe these patients much more easily than if they were scattered over the hospital.

Every patient brought to the room has a blood pressure cuff applied to his arm as soon as he arrives. It stays in place during the entire period that he remains there, and readings are made at least every 10 or 15 minutes. The room has every type of resuscitative apparatus and is manned by nurses especially trained to care for extremely ill patients who have undergone serious operations. A resident fellow also is assigned to the recovery room, and although he does not remain there at all times he is immediately available and can be summoned at a moment's notice.

The time that the patient remains in the recovery room varies according to the procedure and the condition of the patient. All patients remain until they have recovered completely from the anesthetic or the effects of the operation. Patients who have had relatively simple procedures, such as an appendectomy, are returned to their rooms usually within six to eight hours. Patients who have been subjected to more extensive procedures—pneumonectomy, lobectomy, esophagogastrectomy—remain in the recovery room at least 24 hours and frequently 48 to 72 hours.

Although it may appear on first appraisal that a recovery room is an expensive luxury, ours has paid dividends in saving lives. We are convinced that such a facility is a necessity in hospitals where complicated operations are performed. Only in this way can critically ill patients be treated adequately in the immediate postoperative period. — ALTON J. OCHSNER, M.D., *president of the board, Foundation Hospital, New Orleans.*

two cribs for five operating rooms and one cystoscopy room. On a few occasions all of the beds have been occupied simultaneously. There is space for several additional beds should they be necessary.

In addition to patient space, there must be space for a desk, which should be so placed as to permit visual coverage of all patients. There should be a utility room area with a sink, a work bench, a cabinet for storing utensils and linens, a bedpan washer, a utensil sterilizer, and a small instrument sterilizer. A cabinet is needed for storage of a sterile tracheotomy set, airways, nasal and urethral catheters, gastric tubes, sterile syringes and needles, intravenous solutions and equipment, sphygmomanometers (if the conventional type is used), arm rests, and miscellaneous supplies such as celluwipes and tongue blades. A resuscitator should be standard equipment.

Some hospitals also keep laryngoscopes, bronchoscopes and endotracheal tubes in the recovery room. Ours are kept in the operating rooms from whence an anesthesiologist is summoned when needed. A locked drawer should be provided for the medications commonly used, such as narcotics, stimulants, sulfonamides, antibiotics and intravenous vitamin preparations. A dressing cart with the usual instruments and supplies is needed. Unless the blood bank is adjacent to the recovery room, a refrigerator should be available for storage of blood.

SPACE REQUIRED

It is estimated that 200 square feet of space, in addition to bed space, is required for this equipment. A 16-bed recovery division with 86 square feet per bed plus space for utilities and equipment will require a total area of 1,576 square feet.

Some other items, which do not require an appreciable amount of additional space, are a telephone, a central clock with a sweep second hand, a doctor's call system and bedside tables or shelves. This brings us to the last two, but also two of the most important, items of equipment—facilities for suction and for oxygen therapy. The

best suction system consists of a central vacuum pump and tank, built-in piping, and dual outlets at each bedside, one for tonsillectomy and adenoidectomy suction, the other for gastrointestinal and chest suction. Oxygen also is best supplied from central bulk storage, or a central manifold system with built-in piping and bedside outlets having attached flowmeters and humidifiers. A small amount of space somewhere outside of the recovery room is needed for each of these facilities.

The number of persons required for adequate patient care again depends on several factors. These are: (1) The types of surgery, (2) the length of time spent in recovery by the patients, and (3) the number of hours per day that this facility is in use. Again striking an average from the available literature, it appears that a ratio of one person (registered nurse) for every three beds comprises the usual staff and that recovery rooms are open for patient care only during the day, opening between 7 and 8:30 A.M., and closing between 5 and 8 P.M. Usually they are closed Saturday afternoons, Sundays and holidays.

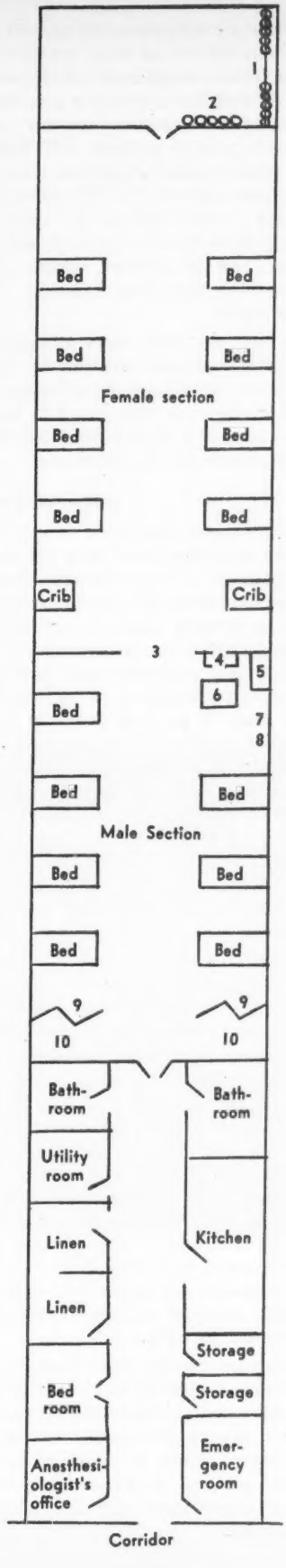
Our recovery division is open and staffed 24 hours a day throughout the year. An average of 247 patients per month are cared for, and, as noted above, the average time per patient is 12 hours. Some patients, such as those who have had pneumonectomies or lobectomies, esophagogastrectomies, craniotomies, laryngectomies, and surgery for cardiovascular anomalies or toxic thyroids, usually remain overnight. We have had as many as eight patients at a time remain overnight, and they average 90 per month. As a result, we have nine nurses, three medical aides, and three orderlies regularly assigned to the recovery division. Day by day coverage is as follows:

Nurses: 7 A.M. to 3 P.M.—Four or five Monday through Saturday, one Sunday.

3 P.M. to 11 P.M.—Three Monday through Friday, two Saturday, one Sunday.

11 P.M. to 7 A.M.—One.

We have several "P.R.N." *(pro re nata—as occasion arises)* nurses with considerable recovery room



LEGEND: (1) oxygen manifold; (2) reserve oxygen cylinders; (3) partitions with windows; (4) file; (5) cabinet; (6) nurse's desk; (7) lavatory; (8) fountain; (9) bed screens; (10) equipment storage.

experience. They furnish additional help on busy nights, and relieve the night nurse on her nights off.

Medical Aides: 7 A.M. to 3 P.M.—One.

10 A.M. to 6 P.M.—One (normal hours, 10 to 6, but relieves others on their days off).

11 P.M. to 7 A.M.—One.

Orderlies: One each shift. A fourth orderly relieves on days off and works elsewhere other days.

RECOVERY ROOM COSTS

In estimating the cost of establishing a recovery room, no attempt has been made to include the cost of construction. The amount of this expense will depend upon the type of construction. Estimates for new construction would not be applicable to alterations in an existing building. Assuming that space has been made available and that utilities have been installed, the cost of equipping a 16-bed room such as has been described would require an additional expenditure of approximately $9,000. It can be done for considerably less.

Rubber tile floor covering and venetian blinds are not essential; their omission from the list of equipment will reduce costs about $675. A set of portable screens may be used in place of cubicle curtains on overhead rods, and will cost $595 less. If the blood bank is near the recovery room, or if there is a refrigerator with unused space nearby, the cost of the latter can be saved. If there is a utility room with a bedpan washer and utensil sterilizer not too far distant, $840 more may be saved. Simple wall shelves in place of conventional bedside tables will permit a further reduction of $500.

A suction system with a central vacuum pump and built-in piping is ideal, but the ordinary gastric and tonsillectomy and adenoidectomy suction machines are satisfactory. Use of these eliminates approximately $1,000 worth of built-in equipment, since the presence of the recovery room does not increase the number of units need-

ed by the hospital. We have experimented with suction from the heating system. A valve is placed at the radiator outlet, connected with the conventional type bottle used in suction, and attached to a mercury manometer. It is a simple inexpensive method of providing suction and has proved quite satisfactory for gastric and chest suction. It has insufficient volume for tonsillectomy and adenoidectomy suction.

With oxygen equipment the situation is similar to that of suction. Ideally, oxygen is supplied from a central supply with built-in piping and bedside outlets, but it can be administered from bedside cylinders, and, again, the existence of the recovery room does not increase the amount of equipment required. Use of bedside cylinders eliminates another $1,800 worth of equipment.

Equipment now has been reduced to essential items, the cost of which is approximately $3,400. These include beds complete with supplies and side rails, a desk, a clock, cabinets, an instrument sterilizer, a dressing cart, sphygmomanometers, and miscellaneous supplies and instruments. If a recovery room is established by converting existing patient space, beds are already available and sphygmomanometers can be concentrated in recovery, reducing the original estimate for equipment to approximately $650.

The question of patient-day costs for operating a recovery division occasionally has been raised. We have made no attempt to determine such costs. Any figure that might result would be meaningless because of this division's effect upon the costs in other divisions. A more pertinent question is, "How much more does it cost to operate the hospital with this facility than it would cost without it?" While we have no before-and-after statistics to support our opinion, the answer is obvious. It costs no more —in fact it costs less. Examination of the facts will support this contention. Charges are made for services while patients are in the recovery room exactly as they would be if they were in their own rooms. There is no loss of revenue to the hospital.

If we were to close the recovery division we would need considerably more additional employees distributed throughout the hospital than we now have in recovery, in order to provide patients with care of a quality approaching that which they now receive. The difference in salaries would amount to appreciably more than the present additional cost of utilities, incidental expenses, and depreciation of equipment.

A recovery room can be equipped at a nominal cost, operated to the economic advantage of the hospital, and at the same time result in patient care of a quality that cannot be duplicated in any other way.

PIPED OXYGEN

If a hospital has some money to spend on items other than the essentials, it is recommended that piped oxygen be considered. If oxygen is already piped to patients' rooms from a central storage system, it is a relatively small matter to extend this system to the recovery room. If no such facilities are present, oxygen can be supplied by a manifold of cylinders; built-in, recessed, or exposed pipelines, and bedside outlets. Only one side of the manifold, controlled by its own regulator, is in service at a time. When the cylinders on one side become exhausted, those on the other side automatically go into service.

There are a number of advantages in the use of piped oxygen. Oxygen is immediately available and more convenient to administer, since cylinders and equipment need not be transported to the bedside and assembled. Cylinders need not be watched with regard to contents, and there is no interruption of supply. Less floor space is required. The room appears more orderly, and there is no danger of overturning cylinders. There is also an economic advantage in that partially emptied cylinders are not returned for filling.

Oxygen can be given from such a supply system by any of the commonly used methods. We administer it almost exclusively by nasal catheter, rarely by mask or tent. This method does not interfere with observation and care of the patient.

Following are a few of the advantages gained by the use of a recovery room. First and most important, only in such a facility can a patient be given the constant, expert care which he should have during the immediate postoperative period. Because of their training and experience, the recovery division personnel are specialists in this phase of patient care.

Personnel and equipment can be concentrated rather than duplicated. Patients also are concentrated, thereby conserving the surgeons' time during their postoperative visits. Unbalanced nursing loads are reduced. Since other divisions are relieved of the burden of immediate postoperative care, they are able to carry on their routine work in a more efficient manner.

Visiting can be controlled. Postoperative patients do not disturb others in their rooms or wards. Private nurses are not needed. The patient receives better care than private nurses could give him, at no additional cost. Relatives and friends are spared a great deal of anxiety caused by the sight and sounds of a patient under anesthesia. The combination of general anesthesia and major surgery is not calculated to render a patient's appearance reassuring in the eyes of his family and friends. They are likely to misinterpret normal reactions to this combination, and, as a result, interfere with the routine work of nurses and other personnel. Last, the anesthetized patient is not placed on exhibition in the hospital corridors and elevators.

FEW DISADVANTAGES

As to disadvantages, there are few. Some authors have stated that occasionally patients object to the lack of privacy in the recovery room and that some patients and relatives object to the "no visiting" rule. We have encountered neither objection. On the contrary, we are continually hearing enthusiastic comments about this division.

The only real disadvantage is that the recovery room causes a duplication of beds. This, however, is a minor disadvantage when weighed against the advantages to the patient in terms of expert care and safety.

HOSPITALS

Journal of the American Hospital Association

Elements of hospital operation

Federal Security Agency

Public Health Service

Division of Medical and Hospital Resources

Foreword

While listing typical problems and situations encountered in opening and operating hospitals the following material is by no means all-inclusive nor are certain portions of it applicable in all cases. An example of the latter will be apparent in the list of "Essential Documents." However, each item should be carefully considered before being checked-off as "not applicable." In like manner no "applicable" item should be checked-off until provision has been made for its solution. It would be well to regard each section and item from the standpoint of its function. Thus, for example, if the hospital will not have a person specifically designated "Chief Engineer" it must be remembered that the functions of the position still exist and must be carried out by others. This thought applies throughout. The evaluation columns are self-explanatory.

Sincere appreciation is expressed to those organizations, agencies, hospital administrators and others who gave such generous quantities of time and so many valuable suggestions in the review of the original manuscript.

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Introduction

It has frequently been stated that when one recognizes his problems he is already well on the road toward their solution. Such was the thought in the preparation of this material. An effort was made to delineate, on a departmental basis, typical problems which must be solved by the hospital. However, for reasons which will become obvious to the reader, it was often necessary to give a statement or partial answer in lieu of merely listing the problem. The governing authority and administrator, for whose use this material was prepared, will realize that the exigencies of the local situation will influence many decisions. Studied familiarity with community attitudes, interests and desires will in like manner bear upon the final policies and procedures adopted. However, it should be remembered that in each hospital, regardless of type or size, certain definite and accepted practices must be observed.

While the material in this manual deals principally with the more tangible aspects of hospital operation, there are other factors, many involving the intangible essentials of the good hospital, which must also be considered.

Community responsibility is a major factor in the establishment and operation of the truly successful hospital. Discharge of this community responsibility may be aided in many instances through cooperation of governing boards, administrators, and hospital staffs not only within the individual hospital but also through the various institutions within an area. This concept is explained in detail in the publication, "Better Patient Care Through Coordination," *Public Health Reports,* November 25, 1949, copies of which are available from the Division of Medical and Hospital Resources, Public Health Service, Washington 25, D. C.

This publication states: "Exchange of knowledge pertaining to hospital services and practices will further promote the contribution of the hospital to better patient care. This is accomplished by providing improved and more efficient clinical services, educational opportunities, and administration."

The publication continues: "However, it must be remembered, as has been stated by C. Rufus Rorem, executive secretary of the Hospital Council of Philadelphia, that co-ordination is a point of view as well as an administrative structure. The inherent advantages can be entirely negated by lack of knowledge, vision, interest, and the egoism of self-sufficiency."

Organization and administration

The governing board

The composition of the governing board will vary by type of hospital according to whether it be a nonprofit community hospital; a church hospital; a governmental hospital, or one run for profit. In the nonprofit hospital, the governing board is wholly and legally responsible for hospital policies, property, and services. It is usually self-perpetuating. In many instances, in governmental hospitals, the institution is administered by an appointed officer who is responsible to some higher officer in a department having many other functions. There may or may not be at least an advisory council. Without such a body, this is not usually conducive to good management. In church hospitals, governing boards are quite often remote. This in many ways is not to the advantage of the community.

In any event, the size of the governing board, while varying with the community and its needs, should be sufficiently large to have major elements represented, yet it should not be so large as to make smooth functioning impossible. The late Dr. Warren P. Morrill, of the American Hospital Association, stated that it is generally conceded that it should consist of an odd number and that the smaller the number the more care is used in selection and the greater interest they take in their duties. There may be circumstances under which five would be proper, but in general, the minimum should be seven to nine. A large number dilutes the active duties of individual members, which tends to discourage interest. Needless to say, members should not derive monetary gain from their participation.

Representation should be from a wide cross-section of responsible community groups. The inclusion of a member of the medical staff on the governing board places the hospital in position of criticism.

Board members should be fully informed concerning hospital matters. They should be familiar with the physical facilities; should keep abreast of hospital literature and reports, including a subscription to the journal, TRUSTEE, published by the American Hospital Association. They should be encouraged to join and attend hospital association meetings and to exchange thoughts and ideas with other experienced board members. It is essential that members be assigned specific duties on committees, of which the more commonly named are: The finance committee, the joint advisory committee, professional committee, public relations committee, buildings and grounds committee, or the executive committee.

Twenty-five years ago, the American Hospital Association defined the duties of the governing board as follows: To determine the policies of the institution with relation to community needs; to see that proper professional standards are maintained in the care of the sick through their direct legal responsibility for the exercise of due care in the appointment of the medical staff and such other actions as are necessary to proper attention to the patient; to coordinate the professional interest of the hospital with administrative, financial, and community needs; to direct the administrative personnel of the hospital in order to carry out the above policies; to provide adequate financing both as to securing a sufficient income and as to enforcing such businesslike control of expenditures as are consistent with proper hospital function.

The section which follows, like others in this manual, does not outline all points which should be covered nor all the problems which will be encountered by the institution's governing body. However, it is felt that detailed attention to each factor, with reference to the publications listed in the bibliography, will enable trustees and directors to administer the affairs of the hospital in a manner which will contribute to the unceasing interest of the patient and the community.

1. The membership of the governing board is representative of the community..... ____
2. The governing board is guided in its actions by formal constitution and by-laws..... ____
3. The length of term of members of the governing board is limited..... ____
4. Terms of governing board members are staggered ..... ____
5. Members of the medical staff are not members of the governing board..... ____
6. The governing board delegates definite managerial authority to an administrator..... ____
7. Individual members of the board do not interfere in the operation of the hospital..... ____
8. Board membership consists of an odd number of individuals..... ____
9. Board members do not derive monetary gain from their participation..... ____
10. Meetings of the governing board are held at least once a month..... ____
11. The administrator attends board meetings.... ____
12. Attendance at board meetings is as nearly 100% as is possible..... ____
13. Formal review of qualifications and appointments to the medical staff are made by the governing board..... ____
14. Proper professional standards are maintained because of legal responsibility for exercise of due care in the appointment of the medical staff, such as limitation of surgical privileges to qualified surgeons..... ____
15. There is full understanding of the legal and moral responsibilities for hospital policies, property and services..... ____
16. Specific duties on committees are assigned to all board members..... ____
17. Committees established and actively functioning include finance, joint advisory (with medical staff), public relations, buildings and grounds ..... ____
18. Sufficient operating income is made available ..... ____
19. The hospital services are coordinated with other hospitals and community resources..... ____

REFERENCES

"The Governing Board of the Hospital"
"Code of Hospital Ethics"
TRUSTEE (a monthly publication)
American Hospital Association, 18 East Division Street, Chicago 10, Ill.

The administrator

In direct charge of the hospital, representing and responsible to the governing body, is the administrative officer.

The responsibilities of the administrator are delegated by the governing board and to carry out these responsibilities there must be matching authority. Webster defines "responsibility" as a "moral accountability." Pursuing this idea further to determine to whom the administrator owes a moral accountability and how he may satisfy this obligation it follows that, in addition to his immediate responsibility to the governing board, he also must answer to the patient, the medical staff, the hospital personnel, and to the community. His success or failure as a hospital executive officer is measured in terms of his ability to fulfill these obligations.

In delegating administrative authority to the hospital administrator the governing board establishes a relationship in which it depends entirely on the administrator to carry out its expressed policies. It expects in return to be kept fully informed on the results produced and the methods and details used to obtain them. The governing body also expects counsel from the administrator in the formulation of policy. His familiarity with detail of operation makes his advice invaluable in this respect. Likewise his presence at the deliberations of policy-shaping enables him to carry out not only the expressed determinations but to interpret and be guided by the intent behind them.

It is the responsibility of the administrator to prepare a budget for approval by the governing board. In this should be indicated the estimate of receipts with advice as to any amount which may have to be raised to supplement patient income. Also contained in the budget is an estimate of expenditure which, when approved by the board, becomes the authority for the administrator to make such expenditures. Any fund raising that may be necessary is a primary responsibility of the board which should not be delegated, although the administrator may be expected to assist in such a campaign.

The responsibility of the administrator to the patient is a vital one and second only in importance to the relationship of the physician to the patient. Both legally and morally the patient places himself in the hands of the hospital, as personified by the administrator, with implicit faith that everything for his safety and proper care will be provided.

The administrator is obliged to the medical staff to provide and maintain facilities, equipment, and assistance in order that the patient may be restored to health as quickly, safely, and pleasantly as is possible.

Hospital personnel may reasonably expect that the administrator provide them with a framework of organization and proper physical facilities in which they may carry out their assigned duties. He must be ever cognizant of their needs and must coordinate and correlate their efforts. He must provide them with decent working conditions, see that they are adequately compensated, and furnish an incentive for increased efficiency. The duties of the administrator are not limited by the walls of his own institution. Hospitals are maintained by communities so that they may have service. In order to better provide this service it is incumbent upon the administrator to ascertain that his methods are keeping pace with new developments in the field generally. To do this he must cooperate with other hospitals, participate in local and national organizations which are constantly striving to improve service, and bring back for his own institution the progressive ideas which are developed.

Departmental organization

Departmental organization varies in degree according to the type and size of the hospital. However, certain principles apply in all instances. The most elemental departmental division would be *administrative* and *clinical*. Detailed organization can stem only from these two.

In the larger hospital the administrative departments will be those dealing with admitting and accounting; purchasing and stores control; plant operation, maintenance and repair; personnel; housekeeping and laundry and linen services. The clinical departments include the medical service; laboratory, x-ray, dentistry, and pharmacy; nursing; dietary; and medico-administrative services such as social service and medical records. Such divisions may be developed further as required and in the larger hospital rather rigid lines of supervision must be drawn. Such is not necessarily the case in the small hospital. However, regardless of the size of the plant, it is necessary for employees to know to whom they are responsible. Also, duplication of work must be eliminated.

In the small hospital, the following departments are thought to be desirable:

A. *Administrative:* (1) Business office, (2) plant operation, maintenance and repair, (3) housekeeping and laundry service.
B. *Clinical:* (1) Nursing service, (2) dietary service, (3) other professional services.

This is an example of extreme simplification in departmental organization.

The principal thing to remember is that such organization must be tailored to fit the specific hospital in question. However, it is always of the greatest importance that the functions and relations of each position be defined while yet indicating the very real interdependency that all departments bear in relation to each other, for the *functional organization* of any hospital, like its accomplishments, is only as strong and outstanding as the individuals who conceive and administer it.

Essential documents

The operation of any hospital requires a number of official certificates, permits, licenses and similar documents. The procurement and utilization of these cannot be avoided since most are required by laws or regulations of the federal, state or local governments.

While it would be most unusual for any hospital to be required to possess all of the documents in this list there is still the possibility that in some localities an even greater number may be prescribed.

In order to determine which are necessary it is suggested that hospital authorities direct inquiries to such offices and agencies as the following well in advance of the anticipated opening day of the hospital:

1. The office of the state attorney general.
2. The state agency concerned with the administration of the program of hospital licensure.
3. The state board of health.
4. Local authorities, such as the office of the mayor, city clerk or county clerk.

It should also be remembered that the titles of the documents shown are descriptive in nature. Actual titles may vary in different localities.

As a rule the authority which issues the document will specify the manner in which it is to be displayed. However, it was thought advisable to call attention to the fact that consideration should be given to this in connection with each category of essential documents as well as to point out that certain of the documents may be difficult to replace if lost or destroyed and hence should be reproduced photostatically or otherwise protected in a manner similar to that shown.

Licenses or certificates of competency presented by persons seeking employment should not always be taken at face value. The employer should check with the agency

issuing the license or certificate in order to determine that it is current and has not been suspended or revoked for cause.

1. Charter or certificate of incorporation of the hospital _____
   (1) Original framed (if indicated) and located in administrative office _____
   (2) Photostatic copy in hospital vault or safety deposit box _____
   (3) Photostatic copy in minutes of board of governors _____
2. Hospital licenses (state or local) _____
   (1) Original framed; located in lobby _____
3. Building construction plans, specifications, and contracts _____
   (1) Master copy in administrator's files _____
   (2) Complete set of plans and specifications for chief engineer _____
   (3) Additional copies for future needs _____
4. Administrator's license _____
   (1) Framed; located in administrator's office _____
5. Association registration or membership certificates (American Hospital Association, state or regional associations, American College of Surgeons, American Medical Association, Blue Cross); displayed in lobby _____
6. Tax exemption certificates (state, federal, local) _____
   (1) Originals in hospital vault _____
   (2) Copies in administrator's files _____
7. Narcotic permits, federal and state (see "Drug Room") _____
   (1) Original in pharmacy or purchasing department _____
   (2) Registry number recorded in office of pharmacist and purchasing agent _____
8. Tax-exempt alcohol permits (same as narcotic permits: see "Drug Room") _____
9. Narcotic order blanks procured (kept in vault or safe) _____
10. Laboratory license or special certificates _____
    (1) Framed in main laboratory _____
    (2) Copy in hospital vault _____
11. Pharmacy license (same as laboratory) _____
12. Pharmacist's license (same as laboratory) _____
13. Sanitary inspection certificate _____
    (1) Framed; located in accordance with local laws _____
    (2) Copy in administrator's files _____
14. Food handlers certificates _____
    (1) Displayed in accordance with local laws _____
    (2) Recorded evidence in administrator's or dietitian's files _____
15. Boiler inspection certificates _____
    (1) Framed; located prominently in boiler room or as required by law _____
    (2) Copy chief engineer's files _____
16. Chief engineer's permit or license _____
    (1) Framed, conspicuous location in engine room or as required by law _____
    (2) Copy (substantiated by investigation) in administrator's office _____
17. Watch engineer's certificate (same) _____
18. Firemen, oilers, wipers certificates (same) _____
19. Electricians certificates (same) _____
20. Projectionists certificates (same) _____
21. Plumbers certificates (same) _____
22. Steamfitters certificates (same) _____
23. Elevator operators certificates (same) _____
24. Motor vehicle operators permits (automobile, passenger; ambulance; truck; bus) _____
    (1) Original carried by operator _____
    (2) Recorded evidence of permit in administrator's files _____
25. Motor vehicle registration _____
    (1) Placed in vehicle in accordance with law _____
    (2) Copy in chief engineer's files _____
26. Elevator inspection certificates _____
    (1) Framed; in elevator _____
    (2) Copy in chief engineer's files _____
27. Machinery permits other than boiler (ammonia, freon, air compressors; diesel, gas or gasoline engines; generators and major electrical equipment) _____
    (1) Original operating permit displayed as required by law, otherwise prominently in engine room _____
    (2) Copy in files of chief engineer _____
28. File inspection certificate _____
29. Safety inspection certificate _____
30. Workmen's compensation certificate _____
31. Special labor certificates _____
32. Notary public's certificates _____
33. Special officer (guard or watchman) permit _____
34. Titles, deeds, contracts and mortgages are properly safeguarded _____

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In the office of the administrator there is recorded and witnessed evidence of the proper licensure or certification of the following personnel.

35. All physicians, surgeons, dentists and oral surgeons on salary or commission (including radiologist, pathologist and anesthesiologist) _____
36. Technicians and technologists (x-ray and laboratory) _____
37. Anesthetists (R.N.'s) _____
38. Full or part-time registered, graduate nurses _____
39. Practical nurses _____
40. Dietitians _____

Insurance for the hospital

In many respects this is one of the most important areas of hospital administration and, for both economy and protection, will require careful consideration by the governing board and administrator. While there is certainly no reason to maintain more insurance than necessary this is preferable to having inadequate property and liability coverage.

The points listed in the following section should be investigated in detail by the administrator and the insurance committee of the governing board of the hospital. It may be well to seek the services of a recognized consultant in the field of hospital insurance. The advice of local insurance company representatives should also be considered and may prove invaluable. However, the problems encountered in hospital insurance, whether they involve public liability, malpractice or property coverage, differ in so many respects from other categories of commercial insurance that the representative whose specialty is life or fire insurance may at times find it difficult to give consultation on the very issues involved.

1. All policies are examined by a disinterested expert prior to and following their purchase and are safely stored in a fireproof place _____
2. Insurance purchases are consolidated as much as possible (divided purchases are minimized) _____
3. All applicable laws regarding negligence and malpractice have been studied _____
4. Insurance register and other necessary records have been set up to insure continuous coverage and reduction or increase in policy values as indicated by changing conditions _____
5. Safety inspection team (e.g. chief engineer, administrator and director of nursing) makes regular, periodic inspections of premises and records results in writing in an inspection log (see also "Safety in the Hospital") _____
6. All employees are under workmen's compensation insurance _____
7. Policies permit storage of explosive or highly

inflammable anesthetics and chemicals..... ____

8. The carrier states *in writing* that he will not forego a legitimate claim because of laws exempting eleemosynary institutions..... ____
9. The carrier states *in writing* that he will not compromise or settle *any* claim without the prior written consent of the hospital..... ____
10. The responsibilities of the carrier are mutually understood ..... ____
11. The responsibilities of the insured are mutually understood ..... ____
12. Both hospital and radiologist are protected by special endorsement relating to use of x-ray and/or radium..... ____
13. Trustees, officers and employees (including voluntary workers) are fully protected against all suits for real or alleged injuries ____
14. All outside contractors provide workmen's compensation for their employees..... ____
15. All salaried physicians and surgeons, or those on commission, are fully protected..... ____
16. Pharmacist's liability ..... ____
17. Products liability ..... ____
18. All nurses are protected under malpractice insurance ..... ____
19. All employees are covered under blanket bond providing "All Risk Money and Security" coverage ..... ____
20. Elevator liability ..... ____
21. Contingent liability ..... ____
22. Theft of, or damage to, property of patients or visitors is covered..... ____
23. Accounts receivable insurance is provided.... ____
24. Burglary, theft, larceny and robbery insurance covers burglary, theft, personal holdup, safe burglary, messenger and office robbery, employees' personal effects, paymaster robbery and loss or theft of securities and cash or valuables ..... ____
25. Plate glass insurance provided..... ____
26. Principal employees are properly bonded..... ____
27. Insurance against theft or disappearance of equipment and supplies is provided (including camera, motion picture and radium loss insurance) ..... ____

Motor vehicle liability insurance, including the following:

28. General public liability and property damage ____
29. Bodily injury ..... ____
30. Medical care ..... ____
31. Non-ownership liability ..... ____
32. Suits for "mental anguish," "loss of work," etc. ..... ____
33. Hired vehicle coverage..... ____
34. Operator's liability ..... ____
35. Motor vehicle comprehensive insurance is provided and includes fire, theft, windstorm, hail, collision, etc..... ____

Fire and property damage insurance including the following:

36. Sound insurable value of all property is determined by appraisal and inventory preferably by a recognized appraisal company and maintained thereafter by the hospital..... ____
37. All property descriptions are accurate..... ____
38. All policies contain the full and correct legal name and address of the insured..... ____
39. If there are encumbrances against the property the endorsement to the policies of all persons holding such encumbrances has been properly secured and entered and all easements recorded ..... ____
40. The advantages of "co-insurance" have been studied ..... ____
41. All "blanket coverage" possibilities have been thoroughly studied..... ____
42. All concessions or allowances which might reduce policy costs have been investigated (fire sprinkler systems, detection and alarm systems, watchman, etc.)..... ____
43. The buildings and their contents (including "fine arts insurance")..... ____
44. Lightning insurance ..... ____
45. Use and occupancy coverage..... ____
46. Aircraft damage (falling airplanes)..... ____
47. Sprinkler leakage ..... ____
48. Water damage per se..... ____
49. Explosion coverage (pressure vessels, gases, etc.) ..... ____
50. Riot and civil commotion..... ____
51. Windstorm, cyclone and tornado..... ____
52. Hail insurance ..... ____
53. Earthquake ..... ____
54. Livestock ..... ____
55. "Inland marine" including: Inland transit, parcel post, registered mail..... ____
56. There is coverage to provide protection against malicious mischief, vandalism, etc..... ____
57. Property coverage policies do not include insurance on the foundations of building..... ____
58. Policies provide insurance for the whole or partial collapse of any building..... ____

Steam boiler and machinery insurance provides both direct and indirect coverage and includes (for extended coverage):

59. Unfired vessels ..... ____
60. Engines and generators..... ____
61. Reciprocating pumps and compressors..... ____
62. Power interruption insurance..... ____
63. Expediting coverage ..... ____
64. Boiler and machinery use and occupancy.... ____
65. Boiler and machinery breakdown..... ____

Reference: Bulletin "Insurance for Hospitals"—American Hospital Association, 18 E. Division Street, Chicago 10, Ill.

Accounting and business office

The accounting and business office is the focal point for a number of inter-related functions which can best be performed when grouped under a single head. Care in selecting a person qualified to assume responsibility over the admitting office, telephone service, cashiers, bookkeepers and business office clerical staff will insure that these functions are properly correlated.

Whether the hospital is large or small these functions must be performed. In the larger hospital the responsibility for carrying them out may be divided among many persons; in small hospitals they may be shared by a comparatively small group. In any case, however, there must be direction, supervision and responsibility for coordinating all activities of the business office to insure a competent organization capable of producing results in the most efficient manner.

It is also well to make certain that the proper space and staff requirements are met. The necessity for mechanical office and bookkeeping equipment must be carefully considered. Generally the smaller hospital business office can be efficiently operated with an adding machine, typewriter and check protecting machine while in larger installations more elaborate bookkeeping machines become desirable. This latter type of equipment requires trained personnel who may be difficult to acquire and retain.

A smoothly operating business department will reduce the day-to-day problems in administration not only in the area immediately concerned, but throughout the hospital.

1. Select the person who will be delegated the duties of office manager, comptroller, chief accountant or other title which will identify him as having general overall supervision over the employees in the following offices ____
   (1) Admitting office ..... ____
   (2) Telephone service and information desk ____

(3) Cashiers _____
(4) Bookkeeper _____
(5) Clerical staff _____

2. Determine the number of employees required for each function and select those deemed qualified and competent by education and experience to perform the various duties of each position to be filled _____
3. Delegate to those employees selected for the several positions in the respective offices aforementioned the duties and responsibilities of each position (or delegate duties of combined positions) _____
4. Establish and maintain an adequate accounting system containing these basic essentials* _____
   (1) Cash receipts journal _____
   (2) Cash disbursements journal _____
   (3) Voucher register or accounts payable journal _____
   (4) General journal _____
   (5) General ledger _____
   (6) Subsidiary records _____
      a. Accounts receivable ledger _____
      b. Accounts payable ledger (if not on voucher system) _____
      c. Equipment ledger _____
      d. Employees' earnings records (including tax procedures) _____
      e. Payroll journal _____
      f. Inventory records _____
      g. Other subsidiary records as may be required such as: _____
         1. Expense ledger _____
         2. Income ledger _____
         3. Inventory ledger, etc. _____
5. Establish policies and procedures relative to budgets _____
   (1) General budgetary considerations _____
      a. Provide for essential flexibility _____
      b. Determine effect of changing economic conditions (in relation to income and expense _____
      c. Maintain continuous studies of employment trends _____
      d. Make periodic investigations into the rate structure of the hospital _____
      e. Give consideration to such factors as income from endowments, governmental agencies, welfare organizations, etc. _____
   (2) Budget preparation (forecast of anticipated income and expense) _____
      a. Prepare income and expense budgets on a departmental basis _____
      b. The income budget includes sources of all anticipated income and amounts from each source _____
      c. The expense budget contains estimates of funds which will be needed by each department of the hospital for salaries, supplies, repairs and other expenses, including capital expenses _____
      d. The cash budget, forecasting cash funds which will be available for payment of expenses _____
         1. Prepare, preferably month-by-month, an estimate of cash income from all sources _____
         2. Prepare, for corresponding periods, an estimate of all cash disbursements which will be necessary _____

*It is recommended that the American Hospital Association's "Handbook on Accounting, Statistics and Business Office Procedures for Hospitals" be used as the basis for establishing an adequate system.

6. Establish internal controls _____
   (1) Provide for adequate cash receipts preferably pre-numbered _____
   (2) Internal check and audit of written cash receipts _____
   (3) Disbursement by check _____
   (4) Petty cash vouchers under the Imprest System _____
   (5) Deposit cash receipts intact (preferably daily) _____
   (6) Employees accepting cash from patients should not have access to accounts receivable records _____
   (7) Reconciliation of monthly bank balances _____
7. Establish banking procedures _____
   (1) The operating bank account _____
   (2) The payroll bank account _____
   (3) Authorization to sign checks _____
   (4) Special bank accounts for special and restricted funds _____

Note: For legal as well as obvious control reasons, it is necessary to maintain separate accounts for certain gifts, bequests, endowments, trust funds, etc. "Commitment" or "Guardian" patients may also require the maintenance of special accounts.

8. Establish policies and procedures relative to cash _____
   (1) Delegation of individuals for handling cash _____
   (2) Arrange for bonding of employees responsible for cash _____
9. Hospitalization and assistance programs _____
   (1) Establish procedures for processing patients having hospitalization insurance _____
      a. Blue Cross _____
      b. Commercial _____
   (2) Provide following data _____
      a. Index of Blue Cross plans and benefits _____
      b. Index of commercial plans in force in the area and their benefits _____
      c. File of forms required by the various companies _____
      d. File of forms permitting release of medical information _____
   (3) Maintain index of all agencies, state, federal, and voluntary, having funds available for the care of patients _____
   (4) Consider contract relations with these agencies _____
   (5) Keep agency authorization up-to-date. (Prompt reports to these agencies will be one factor in continued agency aid.) _____
10. Maintenance of purchasing, receiving and storeroom records (see also "Purchasing and Stores Control") _____
   (1) The maintenance of adequate inventory accounts _____
   (2) Account adjustments following physical inventory (applicable to perpetual or other inventory control system) _____
   (3) The use of stores requisitions as accounting office records used to charge departments with the cost of supplies issued _____
11. Patient and departmental statistics _____
   (1) Necessity for _____
      a. To establish administrative control over functional activities _____
      b. To provide basis for preparing budgets _____
      c. To render reports to the governing board, outside agencies, etc. _____
      d. To provide a basis for the distribution of expenses when computing costs of operations _____
      e. To provide a basis for the calculation of average income and costs per unit of service rendered _____

(2) Essential statistics _____
a. Daily census _____
b. Daily statistical report to administrator _____
c. Monthly statistical summary _____
d. Average occupancy by services or floors _____

12. Establishment of credit and collection procedures _____
(1) Credit and collection policies governing admission of patients _____
(2) Importance of determining a patient's credit rating at time of admission _____
(3) Arrangements for guarantor of the hospital bill, if warranted _____
(4) Procedures applicable to payments in advance _____
(5) Collection procedures during the hospital stay _____
(6) Collection procedures at time of discharge _____
(7) Presentation of final bill and arrangement for payments _____
(8) Acceptance of notes and post-dated checks _____
(9) Installment payments of hospital accounts _____
(10) Collection procedures after patient's discharge _____
a. Follow-up methods (aging of accounts, etc.) _____
b. Use of the collection letter _____
c. Use of the form letter _____
d. Personal contact with patient _____
e. Use of collection telegrams _____
f. Referral of accounts to collection agencies or attorneys _____

13. Provide for uncollectible accounts receivable _____
(1) Direct charge off system _____
(2) Reserve system _____

REFERENCES

"Handbook on Accounting, Statistics and Business Office Procedures for Hospitals." The American Hospital Association, 18 E. Division Street, Chicago 10, Ill.

"Hospital Nursing Service Manual." The National League of Nursing Education, 1790 Broadway, New York 19, N.Y. 1950. (For formulating nursing service budgets).

Establishing hospital charges

1. Make analysis of anticipated costs (see "Business Office and Accounting") _____
2. Compile list of charges of neighboring hospitals of similar size and type _____
Suggested Methods:
(1) Conference with representatives of: _____
a. State hospital association _____
b. Hospital care prepayment and insurance programs _____
(2) By direct inquiry _____
3. In establishing charges consider _____
(1) All hospital expenses, including _____
a. Depreciation (buildings and equipment) _____
b. Uncollectible accounts _____
(2) Nonhospital expenses _____
(3) Care of the medically indigent (consider use of "Hospital Statement of Reimbursable Cost"—Joint Hospital Form 1, U. S. Budget Bureau) _____
(4) Allowances and courtesy discounts _____
4. Determine system to be followed, giving careful consideration to all factors involved _____
(1) All inclusive rate _____
(2) Partially inclusive rate _____
(3) Charge for unit service rendered _____
5. Provide "luxury" service only after study is made of community demand and ability to pay _____
6. Establish rates and methods of collecting charges for patients sponsored by welfare organizations, governmental agencies, etc. (Every effort should be made to secure costs.) _____
7. Determine policies and procedures relative to the handling of professional fees for the radiologist, pathologist and anesthesiologist (for information refer to publications of various national organizations for their views) _____

Admitting and discharge of patients

I. *Admitting*
1. Designate personnel responsible for admitting patients* _____
2. Provide for 24 hour, seven days a week coverage of the admitting office _____
3. Attractive surroundings and privacy are essential in conducting admitting procedures _____
4. Establish definite admitting procedures (see also "Printed Forms") _____
5. Provide necessary mechanical aids for efficient operation _____
6. Establish policies relative to the release of information about patients to relatives, friends, and the general public (see also chapters on public relations and standing orders) _____
7. Ascertain that the hospital staff is kept informed on policies and procedures _____
8. Coordinate admitting procedures with other departmental routines _____

II. *Discharge*
1. Establish definite routine for discharge of patients (see also chapters on nursing, standing orders, and public relations) _____
2. Acquaint the physician, nurse, social worker, and business office personnel with their parts in the release of patients and coordinate their efforts so as to effectively conclude the "care of the patient" _____

*Give special attention in their selection to the assets of tact, courtesy, ability to appreciate problems of patients, cooperativeness and general intelligence.

Personnel

The success of any hospital is always dependent upon the competency and attitude of its employees. Therefore, the development of sound personnel policies and procedures should be of the utmost concern to the administrator. Although in the larger hospital a personnel officer may be appointed, he cannot relieve the administrator and through him, the governing board, of their ultimate responsibilities in this field.

It should be stressed that the newly organized hospital should not attempt to formulate a complete or static pattern of personnel policies or practices. This is something which must be flexible enough to grow with the hospital and which can be adapted to changing conditions.

However, employment should not begin until certain basic issues have been decided, at least on a preliminary basis, if embarrassment is to be avoided. For example: There must be some policy regarding vacations, sick leave and holidays.

The points which follow deserve the careful consideration of hospital authorities, but as with other sections in this manual, all points will not apply to every hospital and in many cases more issues than those listed will be involved.

1. Centralize personnel functions and designate a capable person to act as personnel officer _____

2. Determine the number of employees required in each position or designate those employees responsible for coverage of duties of combined positions. Establish salary scales for each, based upon job analysis and continuous area wage surveys ____

3. Job classifications ____
   (1) Administrator ____
   (2) Assistant administrator ____
   (3) Accountant ____
   (4) Admitting officer ____
   (5) Bookkeeper ____
   (6) Clerk, general ____
   (7) Clerk, typist ____
   (8) Clerk, file ____
   (9) Clerk, medical records ____
   (10) Clerk, information ____
   (11) Librarian, medical records ____
   (12) Operator, telephone ____
   (13) Purchasing agent ____
   (14) Secretary ____
   (15) Storekeeper ____
   (16) Director of nursing service ____
   (17) Assistant director of nursing service ____
   (18) Supervisor, nursing service, day ____
   (19) Supervisor, nursing service, night ____
   (20) Head nurse, each nursing unit ____
   (21) Head nurse, operating room ____
   (22) Head nurse, maternity unit ____
   (23) Head nurse, dental clinic ____
   (24) Head nurse, central sterilizing and supply ____
   (25) Head nurse, outpatient department ____
   (26) Staff nurses ____
   (27) Practical nurses ____
   (28) Nurse aides (voluntary and paid) ____
   (29) Orderlies and other attendants ____
   (30) Anesthetist ____
   (31) Pharmacist ____
   (32) Dental clinic personnel (including oral hygienists) ____
   (33) Medical technologists (laboratory) ____
   (34) Technicians, x-ray ____
   (35) Technician, dental laboratory ____
   (36) Food service supervisor (or administrative dietitian) ____
   (37) Dietitian, therapeutic ____
   (38) Cook ____
   (39) Assistant cook ____
   (40) Baker ____
   (41) Food handling employees (general) ____
   (42) Dishwashing machine operator ____
   (43) Pot cleaner ____
   (44) Executive housekeeper ____
   (45) Linen service supervisor ____
   (46) Linen room clerk ____
   (47) Seamstress ____
   (48) Maids ____
   (49) Porters and janitors ____
   (50) Laundry supervisor ____
   (51) Washmen ____
   (52) Extractor operators ____
   (53) Tumbler operators ____
   (54) Linen sorters ____
   (55) Mangle operators (including feeders and catchers) ____
   (56) Pressman ____
   (57) Chief engineer ____
   (58) Watch engineers ____
   (59) Firemen ____
   (60) Coal passers ____
   (61) Plumbers ____
   (62) Carpenter ____
   (63) Gardener ____
   (64) Mechanical repairman (utility man) ____
   (65) Electrician ____
   (66) Laborer, general ____
   (67) Painter ____
   (68) Operator, elevator ____
   (69) Operator, motor vehicle (ambulance, truck, automobile) ____
   (70) Operator, telephone switchboard ____

4. List sources of employees ____

5. Provide for adequate interviews of each applicant ____

6. Program induction of each employee (give each new employee a written description of duties, responsibilities, and procedures) ____

7. Give each employee a pamphlet containing pertinent information about the hospital and its personnel policies and practices ____

8. Initiate a general policy program to include ____
   (1) Absenteeism ____
   (2) Holidays observed ____
   (3) Work-day and work-week by job classification ____
   (4) Maintenance policies (room, board, laundry, uniforms) ____
   (5) Transportation problems ____
   (6) Leave policies (e.g. maternity, "without pay," jury duty, military service, sick and vacation) ____
   (7) Compensation for overtime ____
   (8) Provision of uniforms ____
   (9) Promotion of employees ____
   (10) Employee insurance ____
      a. Workmen's compensation ____
      b. Health and hospitalization ____
      c. Accident ____
      d. Unemployment ____
      e. Life ____
   (11) Adequate health program, including ____
      a. Initial and periodic physical examinations (with chest x-ray) ____
      b. Hospitalization (including allowances) ____
      c. Medical treatment ____
      d. First aid ____
   (12) Employee pension plan ____
   (13) Employee recreation ____
   (14) Scheduled employee conferences (individual and group) ____
   (15) Utilization of the physically handicapped (fully studied on a job requirements basis) ____
   (16) Employees credit union ____
   (17) Employees benefit association ____
   (18) In-service training program including the training of each employee in fire prevention, fire fighting, and general safety and disaster procedures) ____
   (19) Educational program for employees, including attendance at institutes and refresher courses ____

9. A uniform system of employee records, including ____
   (1) Adequate application form ____
   (2) Adequate interview sheets ____
   (3) Payroll change forms, such as: ____
      a. New employment notification ____
      b. Transfer slips ____
      c. Termination slips ____
      d. Salary changes ____
   (4) Employee job progress cards ____
   (5) Employee identification (i.e. cards, name-plates, badges) ____
   (6) Employee health records ____

10. Each employee clearly understands to whom he is to report for job assignments ____

11. Minors are not employed without work permit. This information is posted on all departmental bulletin boards ____

12. There is centralized control over all bulletin boards ____

13. Rest room and locker room facilities are adequate ..... ____
14. Provide for frequent area personnel policy surveys (including relations with organized labor) ..... ____
15. Recognize and, if possible, reward employees who submit constructive criticisms or suggestions which are adopted by the hospital.... ____

Reference: "The Development of Sound Personnel Practices for Hospitals"—American Hospital Association, 18 E. Division Street, Chicago 10, Ill.

Public relations

This is not intended to be an exhaustive analysis of hospital public relations. Rather it is a condensation of some of the basic principles involved.

In addition to the points covered it would be well for the hospital authorities to determine what the community expects from the hospital, for too often the hospital assumes that it knows this without any real effort to find out.

Frequently it is practicable to have a technical advisory committee consisting of representatives of the newspapers and radio stations of the community. Such a committee will often be able to render invaluable assistance in matters affecting hospital and community relationships.

When possible it is also advisable for the various hospitals in an area to meet with newspaper and radio representatives for the purpose of formulating a code of ethics governing the release of information concerning patients and hospital activities.

Perhaps a word of explanation is indicated concerning the statement "Inform all employees as to what they may discuss outside of the hospital. Tell them what subjects should not be discussed and *why*." This should not be interpreted as undesirable censorship. Many times hospital personnel will possess fragmentary technical information which, if permitted to enter the rumor factory, will emerge as a finished product, detrimental to both hospital, medical staff and community. A program of employee education is required if such situations are to be avoided. This is one of the many reasons why a sound program in personnel management is so very necessary.

I. Determine the contributions of the hospital to the welfare of the community (past, present and anticipated) ..... ____
   1. Tangible assets to the community..... ____
   2. Intangible assets to the community..... ____

II. Determine what the hospital expects from the community ..... ____
   1. Active, favorable interest in its activities ____
   2. Financial support by the community..... ____

III. Establish policies and procedures relative to the attainment of the active support, interest, and good will of the community. (Determine what the community expects of its hospital) ____
   1. Appoint a public relations committee of the governing board..... ____
   2. Appoint one well-trained employee to deal with public information media (newspapers, radio, etc.)..... ____
   3. Establish a code of ethics governing the release of information about patients, hospital personnel, and hospital activities (in cooperation with newspaper and radio peopie) ..... ____
   4. Give consideration to the formation of supportive organizations ..... ____
      (1) Auxiliary women's groups..... ____
      (2) Hospital association ..... ____
      (3) Community hospital council..... ____
   5. Provide tactful instruction in courtesy for all employees and encourage them to elect an employee committee on courtesy to assist in maintaining the standards created ..... ____
   6. Give special care to the selection and training of admitting officers, receptionists, and other "front office" employees in the matters of tact, kindliness and knowledge of the policies and objectives of the hospital..... ____
   7. Cooperative relationships have been established with other hospitals..... ____
   8. Find out what the various community groups expect of their hospital..... ____
   9. Establish and maintain good employee relations. (See also section on "Personnel") ..... ____
      (1) Pay the "going" wage rates..... ____
      (2) Weigh advantages and disadvantages of "split" shifts..... ____
      (3) Provide good working conditions..... ____
      (4) Provide tactful, understanding and skilled supervision in all departments ____
   10. Inform all employees as to what they may discuss outside of the hospital. Tell them what subjects should not be discussed and *why* ..... ____
   11. Provide for the intelligent, nonbelligerent handling of complaints..... ____
   12. Utilize every opportunity to present to the public the activities and needs of the hospital, but do so in a manner befitting the dignity of such institutions..... ____
   13. Conduct frequent surveys of community opinion, using professionally trained surveyors if possible..... ____
   14. Give the community intelligent, easily comprehended financial reports..... ____
   15. Provide similar clinical reports..... ____
   16. Make adequate provision for answering the questions of patients and visitors..... ____
   17. Consider the publication of a hospital information booklet ..... ____
   18. Provide standard routines that will insure that patients are treated as intelligent individuals ..... ____

Purchasing and stores control

Regardless of the size of the hospital, purchasing remains one of the most important fields of hospital operation. While administrators of many small hospitals also act as purchasing agents, it is doubtful if they actually have sufficient time to devote to these duties. Intelligent purchasing requires much time and thought in even the smallest hospital. Because of this it is essential that it be centered in a qualified experienced person.

1. Designate qualified person who will act as purchasing agent ..... ____
2. Designate capable person who will act as storekeeper (receiving and issuing clerk).... ____
3. Establish centralized control over all purchases and issues..... ____
4. All requisitions for purchases shall be cleared through the office of the purchasing agent and purchase orders are issued only by the purchasing agent or other duly authorized individual ..... ____
5. Install an adequate system of records..... ____
   Suggested as Essential:
   (1) Purchase order ..... ____
   (2) Stores requisition ..... ____
   (3) Perpetual inventory system..... ____
   Suggested as Desirable:
   (4) Purchase record ..... ____
   (5) Purchase requisition ..... ____
   (6) Quotation request ..... ____
   (7) Delivery receipt ..... ____
   (8) Record of goods received..... ____

(9) Return order record ____
(10) Overage, shortage and damage report ____

6. Maintain an index of source of supply of items by categories* ____
7. Maintain a complete up-to-date catalog file ____
8. Establish stores control system ____
   (1) Personnel authorized to originate requisitions ____
   (2) Approval of requisitions ____
   (3) Issue periods ____
   (4) Pricing of requisitions for departmental accounting systems ____
9. Establish definite system for the platform receipt of merchandise and its inspection and storage ____
10. Determine disposition of vendor's packing slips and bills of lading ____
11. Study possibilities of joint purchasing with other hospitals ____
12. Determine in conference with the administration, the frequency of physical inventories ____
13. Establish policy regarding sales of hospital supplies to physicians, employees, and the public ____
14. Develop standard specifications for equipment and supplies throughout the hospital as much as possible, using recommended simplified practices ____
15. Check goods received against specifications or samples submitted ____
16. Purchasing agent confers at frequent intervals with other department heads as to new equipment supplies, possible economies, etc. ____
17. Purchasing department does not make major substitutions without consulting the department concerned ____
18. All stores are centralized, with the possible exception of pharmaceuticals, food and engineer supplies ____
19. All blank forms, records and other stationery are indexed and assigned a form number ____
20. Stock is checked frequently to prevent obsolescence, deterioration and excess quantities. Old stock is moved first ____
21. All long term purchase contracts are carefully investigated beforehand (with reference to changing needs and market trends) ____
22. Arrange timing of deliveries of gas cylinders to reduce demurrage charges ____
23. Check with state board of health, Red Cross, etc., to obtain any free supplies available ____
24. Consider contract purchase of such items as the following ____
   (1) Fuel ____
   (2) Ice ____
   (3) Milk ____
   (4) Eggs ____
   (5) Ice cream ____
   (6) Telephone service (including switchboard) ____
   (7) Surgical soap ____
   (8) Commercial oxygen ____
   (9) Parenteral fluids ____
   (10) Elevator maintenance ____
   (11) Machinery maintenance ____
   (12) Electric power, gas and water ____
   (13) Anesthetic and therapeutic gases ____
   (14) Laundry service ____
25. Remote warehouses are frequently checked as to storage conditions and are properly guarded ____
26. All goods are stored in original, unbroken cases whenever feasible ____
27. Policies with respect to purchases from local versus outside sources should be considered on a basis of transport cost, unit price, delivery lag, maintenance of optimum inventory and public relations ____
28. Consider the appointment of advisory committees on purchasing (medical staff and nursing, etc.) to meet with administrator and purchasing agent ____
29. Study investment in inventory and keep it as low as possible by rapid turn-over of supplies. Study possibilities of yearly contracts with regular monthly deliveries of such items as surgical gauze and dressings ____

*It is suggested that a current copy of *The Hospital Purchasing File* be obtained from the Modern Hospital Publishing Company, 919 N. Michigan Avenue, Chicago 11, Ill. Copies are distributed gratis to hospitals.

REFERENCES

"Purchasing for Hospitals," Walter N. Lacy, 1947, Physicians Record Company, Chicago, Ill.

"Purchasing," Stuart F. Heinritz, 1947, Prentice-Hall, Inc., New York City, N. Y.

Printed forms

The hospital, like so many institutions in our modern society, is faced with an ever increasing amount of "paper work," most of which is unavoidable. However, a careful analysis of requirements for printed materials and an even more careful consideration of their content and construction will often demonstrate ways in which much valuable time may be saved by the clerk, nurse or medical staff. The use of multiple copy forms may well be a solution in many instances. The hospital must remember that only time will tell whether a certain form is adequate for the use for which it was intended. Therefore, it is wise to procure initially only a small quantity, give these a trial and then at the end of a specified test period, determine whether the form should be revised to best meet the needs of the hospital.

It should be pointed out that, frequently, standard forms may be used, as it is unnecessary for the name of the hospital to appear on all printed material. An added advantage is that the price is often considerably lower than that for forms printed especially for the hospital.

A careful index should be maintained by the purchasing agent of all printed forms and stationery, so that accurate control measures may be maintained. It is equally important that periodic inspection be made of stocks of printed material to determine obsolescence or necessity for revision.

Before drawing up any printed forms, all department heads who will have to use them should be consulted.

General

1. Official letterheads ____
2. Official envelopes ____

Business office

3. Bank deposit records ____
4. Checks ____
5. Notes receivable forms ____
6. Cash receipt forms ____
7. Petty cash disbursement slips ____
8. Statements "bill-heads" ____
9. Financial ledgers ____
10. Journals (including capital equipment records) ____
11. Charge slips for special nurses meals ____
12. Patients register ____
13. Insurance register ____
14. Payroll time records ____
15. Payroll journal forms ____
16. Employee earning records (individual) ____
17. Withholding tax forms (W-2, W-4) ____
18. Voucher register ____
19. Special service charge slips (preferably prenumbered) ____
20. Payroll envelopes ____

Admitting office

21. Request for admission ____
22. Admitting Record (includes statistics) ____
23. Request for transfer of patient ____

24. Order for transfer of patient ____
25. Ambulance records ____
26. Census reports ____
27. Room occupancy records ____
28. Operating room reservation ____
29. Patients' valuables envelopes ____
30. Patients' valuables receipts ____
31. Patients' clothing receipts ____
32. Information desk files ____
33. Information desk notices ____
34. Visitors passes ____
35. "Critical list" forms ____
36. Room reservation forms ____
37. Patients' register ____
38. Birth certificates ____
39. Death certificates ____
40. Stillbirth certificates ____
41. Physician "in and out" register ____
42. Patient door or bed identification cards ____
43. Hospitalization insurance forms ____
44. Authority to release information from patient's record ____
45. Payroll deduction authorization blanks ____
46. Workmens compensation report forms ____

Professional care (General)

47. Clinical record identification data sheet ____
48. Graphic chart ____
49. Physicians orders for treatment ____
50. Nurses notes ____
51. Physicians progress notes ____
52. Patients history ____
53. Physical examination (including oral health examination) ____
54. Operation reports ____
55. Anesthesia Records ____
56. Accident reports ____
57. Autopsy reports ____

X-ray reports and forms

58. Request for x-ray ____
59. Radiographic and fluoroscopic ____
60. Superficial and deep therapy ____
61. Radium treatments ____

Laboratory reports and forms

62. Request and report forms (general: for miscellaneous tests) ____
Request and report forms (by specific type of examination) ____
63. Urinalysis ____
64. Blood morphology (hematology) ____
65. Blood chemistry ____
66. Serology ____
67. Sputum ____
68. Gastric analysis ____
69. Spinal fluid ____
70. Feces ____
71. Basal Metabolism ____
72. Electrocardiography ____

Obstetrical charts

73. Patients history ____
74. Physical examination (including oral health) ____
75. Labor record ____
76. Puerperium ____

Pediatrics (including nursery)

77. Infants history ____
78. Nursery record ____
79. Nurses record ____
80. Newborn identification data sheet ____

Miscellaneous

81. Fracture record ____
82. Carcinoma record ____
83. Weight charts ____
84. Exercise charts ____
85. Oral health record ____
86. Physical medicine special charts ____
87. Eye records ____
88. Ear, nose, throat records ____
89. Urology reports ____
90. Neurological examination reports ____
91. Gas therapy chart ____

Professional care (medico-administrative)

92. Permit for operation or special treatment ____
93. Permit for sterilization ____
94. Permit for therapeutic abortion ____
95. Release from responsibility for discharge against advice ____
96. Release from responsibility for condition of abortion ____
97. Authority for autopsy ____
98. Morgue tags ____
99. Release of body ____
100. Record of operations (operating room) ____
101. Record of deliveries (delivery room) ____
102. Permit for photograph ____

Medical record office

103. Analysis of hospital service ____
104. Index of operations ____
105. Index of diseases ____
106. Index of necropsies ____
107. Index of physicians ____
108. Index of patients ____
109. Analysis of caesarean sections ____
110. Discharge record and service analysis ____
111. Birth register ____
112. Death register ____

Medical staff

113. Minutes book ____
114. Staff meeting attendance records ____
115. Application for appointment to the staff ____

Personnel department

116. Application for employment ____
117. Interview sheets ____
118. Employee progress records ____
119. Termination ("cut-off") slips ____
120. Employee health records ____

Pharmacy

121. Prescription blanks ____
122. Requisition for narcotics ____
123. Record of narcotics administered ____
124. Federal and state narcotic, alcohol, liquor blanks (for purchase) ____

Food service department

125. Requisition for diets (regular and special) ____
126. Tray identification cards ____
127. Special diet requisitions ____
128. Special diet identification cards ____
129. Menu form ____
130. Daily food cost record ____

Purchasing and stores control

131. Purchase requisition ____
132. Purchase order ____
133. Stores requisition (general) ____
134. Perpetual inventory records ____
135. Purchase record ____
136. Quotation request ____
137. Record of goods received ____
138. Delivery receipt ____
139. Return order record ____
140. Shipping labels and tags ____

Plant operation, maintenance and repair

141. Work order blanks ____
142. Mechanics work schedule blanks ____
143. Steam production and distribution records ____
144. Ice production and distribution records ____
145. Job identification tags ____
146. Job inspection tags ____
147. Safety direction placards ("Do Not Operate," "Out of Service," "Man Inside," etc.) ____
148. Work order register ____
149. Linen room requisitions ____
150. Laundry slips ____
151. Laundry claim slips ____

Note: Refer to standard forms which are recommended by the various national professional associations.

Safety in the hospital

In the light of certain tragic experiences within recent years, many hospital people have come to associate safety with catastrophe prevention. While this is, of course, of great importance it still remains that total safety programs must not be ignored.

The fundamental responsibility for maintenance of safety rests with the governing board. However, that of the administrator is only slightly less, both morally and legally. Under the administrator some major department head, such as the chief engineer, may be delegated a considerable amount of responsibility. In any case such a person must possess the ability to influence all other personnel if the total safety program is to succeed.

The fire prevention program should be a part of the general safety program, for a well-planned attack on the causes of fire closely parallels similar attacks on the causes of personal injury.

Strong administration is essential.

General safety

1. Appoint hospital safety committee (e.g. administrator, chief engineer and housekeeper, plus medical and nursing staff representatives) _____
   (1) Provide for frequent periodic general safety inspections by this committee, using a check list specifically prepared for the hospital _____
   (2) Record all findings in safety inspection "log", noting, in case of defects, the date when corrective action is taken _____
   (3) Chief engineer has the authority to properly maintain safety and is required to make frequent inspection of the premises. (His responsibility is second only to that of the administrator) _____
2. Arrange for frequent periodic inspections by professional inspectors who are accompanied by the chief engineer when they visit the hospital _____
   (1) Local fire department _____
   (2) State fire marshal _____
   (3) Local or state safety councils _____
   (4) Insurance company engineers _____
3. Copies of adverse safety reports are sent to the chairman of the executive committee of the governing board _____
4. An intensive training program in general safety, fire prevention and fire fighting is conducted for all employees. (See also "Fire Safety") _____
5. All exits are properly marked and maintained. (See "Fire Safety" in re. to fire escapes) _____
   (1) Directional arrow signs, preferably illuminated, are provided along corridors leading to exits _____
   (2) Panic locks are provided on all personnel exits where entry from the outside must be restricted _____
   (3) Exit lights are also served by the emergency lighting system _____
   (4) Exits are kept clear at all times _____
   (5) Exits and entrance steps and ramps are kept free from ice, snow and other friction reducing agents _____
6. Stairs and stairwells are properly maintained, marked, illuminated, and enclosed _____
7. There are vision panels in all double acting doors _____
8. Door checks are regulated to provide safe return speed _____
9. Window sash cords are properly maintained _____
10. Building is frequently inspected for loose slate, bricks, plaster and the like _____
11. Limbs in dangerous conditions are immediately removed from trees _____
12. Special attention is devoted to the prevention of falls by patients, employees and visitors _____
    (1) Floor mats are provided where indicated _____
    (2) Use of throw rugs is severely restricted _____
    (3) Stair treads are properly maintained and tread nosings are selected which have high frictional qualities _____
    (4) Hand rails are provided on all stairs _____
    (5) Bedside rails are of proper design, adequate in number and immediately used when indicated _____
    (6) Footstools are so designed as to reduce danger of tipping and slippage _____
    (7) Wheel chairs are so designed as to prevent danger of tipping. No patient is permitted to operate a wheel chair down or up a ramp _____
    (8) All stretchers are operated by two attendants and stretcher straps or similar devices are employed. Extreme care is taken with stretchers having removable beds when this type must be used _____
    (9) Floor areas being cleaned are roped off or otherwise properly marked _____
    (10) Where there is a variation in floor level illumination is provided _____
    (11) Showers over bathtubs are restricted in patient areas. A restriction on their installation elsewhere is carefully considered. Both showers and tubs have grab bars _____
    (12) Locking devices are provided for crib side rails _____
13. Frequent inspection is made of all plumbing and electrical devices, piping, conduit and cable. (Refer to pertinent plumbing and electrical codes). There is adequate illumination with conveniently located switches _____
14. X-ray tube stand counterweight carrier supports, and cables or chains, are frequently inspected to prevent danger of tube head falling on patient _____
15. Restraints are carefully applied in accordance with hospital and medical staff instructions in such manner that patients may not injure themselves _____
16. Floors are treated and maintained in such manner as to yield maximum frictional quality in conformance with good appearance _____
17. Elevators are properly maintained. Special attention is given to door control safety devices, cables and brakes. Pits and shafts are kept clean _____
18. Policies and procedures are established relative to the proper inspection and use of hot water bottles, electric pads, and similar heat producing devices. Thermostats are provided where indicated _____
19. Measures are taken to protect irresponsible patients from contact with hot radiators (very important in pediatric, nursery and similar areas) _____
20. Combustibles and gases under pressure are stored and used only in accordance with approved methods _____
21. The committee of the governing body responsible for buildings and grounds is kept informed about the safety program of the hospital _____
22. All employees are instructed to report any injury, no matter how small, to their supervisor. Notices are also posted to this effect _____
23. Care is taken to insure that ether cans are

not thrown into trash destined for the incinerator ..... ____

24. Personnel attending patients are instructed in the proper methods of lifting without injury to either party..... ____
25. Patients, particularly fracture, other surgical and pediatric cases are instructed in safety as it pertains to the prevention of accidents to themselves ..... ____
26. Powered machinery in such areas as kitchen, laundry and shops is equipped with proper guards and other safety devices..... ____
27. Employees are instructed to brush up, not pick up, broken glass..... ____
28. Stepladders are properly maintained and are of sufficient height so that employees are not required to use the top step..... ____
29. Window washer hooks are installed where indicated and window washers are required to wear and use safety belts..... ____

Fire Safety

Note: Much of the material covered in section on general safety is applicable to the maintenance of fire safety.

1. A department head is appointed fire marshal to act in the absence of the administrator (e.g. chief engineer) to deal with fire prevention and fire fighting. All shifts are so covered ..... ____
2. Establish written fire fighting program and delegate the specific responsibilities of each employee by job classification..... ____
3. Post fire regulations in prominent locations ____
4. Form trained fire brigade with one person in charge on each shift..... ____
5. Maintain adequate signal system..... ____
   (1) Automatic detection-alarm (Connected *directly* to Fire Department switchboard) ..... ____
   (2) Manual internal notification alarms..... ____
   (3) Provide fire watch-patrol personnel if possible ..... ____
   Note: Especially at night *all* divisions of the hospital should be inspected not less than hourly.
6. First Aid fire fighting equipment is provided in each area, selected in accordance with type of fire which might occur, properly maintained as directed, and checked frequently by competent professional inspectors ..... ____
7. All personnel know how to sound alarm to local fire department and are instructed that there must be *no* delay in sounding alarm.... ____
8. All personnel know how to use extinguishers on all classes of fires..... ____
9. Fire drills are held frequently..... ____
10. Smoke control measures are understood by all employees ..... ____
11. Fire escapes are adequate, properly marked, maintained and illuminated. (See paragraph 9 in preceding section on general safety).... ____
    (1) Fire escape directional arrows are provided ..... ____
    (2) Fire escapes are readily accessible and never blocked ..... ____
    (3) Fire escapes are never used as temporary storage points, for airing of mattresses or any other similar purpose..... ____
    (4) If entrance to fire escape is by way of a window the latter is of the swinging type ..... ____
    (5) If such entrance is above floor level, then inside steps are provided..... ____
12. Standpipes and hose are inspected regularly ____
13. Automatic sprinkler systems are inspected and maintained by experienced personnel.... ____
14. There is an established plan for the evacuation of patients which is understood by all employees ..... ____
15. There is a reasonable policy regarding smoking ..... ____
16. Proper methods are observed in the storage, handling and use of explosive or inflammable anesthetic agents..... ____
17. Special precautions are taken to maintain safety in the operating rooms (e.g. control of static electricity, etc.)..... ____
18. Corridor smoke barriers exist..... ____
19. Combustibles, including oily rags, are properly stored ..... ____

The following national organizations can provide excellent assistance or advice (including manuals, guides, posters, etc.) on fire safety and general safety:

1. National Fire Protection Association, 60 Batterymarch Street, Boston 10, Massachusetts ____
2. National Safety Council, 20 North Wacker Drive, Chicago 6, Illinois..... ____
3. National Board of Fire Underwriters, 85 John Street, N. Y. 7, N. Y..... ____
4. Local or State Safety Councils..... ____
5. The American Hospital Association, 18 East Division Street, Chicago 10, Illinois..... ____
6. The various insurance companies..... ____

Note: The *Hospital Safety Service* which is produced by the National Safety Council and sponsored by the American Hospital Association offers much information to assist hospitals in the development of adequate safety programs.

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Food service

The section which follows was developed for the consideration of the hospital administrator in dealing with the functional organization and operation of the food service department.

Problems in food preparation and service cannot be divorced from other aspects in the professional care of the hospitalized patient. Proper education of the patient in basic dietary facts by the dietitian extends this sphere of influence from the hospital to home care.

In addition, it should be noted that this department plays a vital role in public realtions. It is still true that good food, well and palatably prepared and attractively served, will win many friends. Any variation cannot but have the opposite effect.

1. Designate department head (administrative dietitian or food service supervisor) _____
2. If a fulltime dietitian is not employed, have the services of a consulting dietitian been considered? _____
3. Establish standards of food service such as _____
   (1) Selective or nonselective menus for patients and personnel _____
   (2) Waitress or self-service for employees _____
4. Delegate responsibility for compilation of _____
   (1) Regular diet menus _____
   (2) Modified or special diets menus _____
   (3) Therapeutic diet manual _____
5. Dietitian solely responsible for requisitioning of food and dietary supplies, primarily responsible for developing standard food specifications _____
6. Purchasing agent or his authorized representative purchases all food by grade and classification _____
7. Delegate responsibility for receipt, inspection and storage of food _____
8. There is centralized control over issue of food stores _____
9. In planning of menus the following points are considered _____
   (1) Market trends closely observed _____
   (2) Menus are planned in advance _____
   (3) Careful attention given to use of "in season" foods _____
   (4) Standardized recipes _____
   (5) Food habits _____
   (6) Nutritional adequacy _____
   (7) Money to be spent _____
   (8) Available personnel and equipment _____
   (9) Use of standard, selected utensils to arrive at uniform serving portions ("portion control") _____
10. Adequate food service staff _____
    (1) Number of shifts required _____
    (2) "Split" shifts kept to minimum _____
    (3) A reliable supervisory employee is in the kitchen during all operating hours _____
    (4) Work schedules are planned in advance _____
11. Periodic, adequate health examinations (including chest x-ray) given all food service employees. Daily inspections for personal appearance and health (hair nets, clean uniforms, finger nails, colds, sores and open cuts). Check with state and local health authorities on food handlers codes _____
12. Establish policy for providing adequate uniforms and laundering of same _____
13. Dishes, clean and soiled, are handled and stored in a sanitary manner. Sanitary regulations are observed _____
14. Establish policy for "between meal" nourishments (juices, etc.) to patients and for food brought to patients by visitors _____
15. Establish policy in regard to serving meals to employees _____
16. Establish policy regarding serving of meals to visitors, private duty nurses and physicians _____
17. Establish procedures involving food service and dish handling to isolation cases _____
18. Establish procedure for purchase of perishable food supplies (i.e. contract purchase, open market purchase, emergency purchases) _____
19. In serving milk, observe current governmental sanitary regulations, giving careful consideration to the fact that it should be procured from an approved source, pasteurized and served to employees and patients in individual sealed containers _____
20. The department will maintain records to show the number of meals served to:
    (1) Patients _____
       a. Regular diets _____
       b. Modified diets _____
       c. Nourishments _____
       d. Infant formulas _____
    (2) Employees _____
    (3) Private duty nurses _____
    (4) Visitors _____
21. Will the dietitian visit all patients? _____
22. There is a definite system for handling complaints _____
23. Surplus quantities of prepared foods are properly handled and stored (refrigerated) until served _____
24. Adequate measures have been instituted for the continuous control of vermin _____
25. A continuous, organized in-service training program is maintained for food service personnel _____
26. The special service facilities of the state and local health departments, such as food handlers training courses, are fully utilized _____
27. Establish procedure in regard to preparation and distribution of infant formula. (This is

sometimes a nursing service function) ..... ____

28. Establish adequate and sanitary methods for handling and disposing of garbage and waste. Is check made of garbage to recover lost silverware and utensils? ..... ____

29. Determine who is to be responsible for the final check of the patient's tray. The tray should be checked for:
    (1) Identification data ..... ____
    (2) Attractiveness of tray, arrangement, eye appeal ..... ____
    (3) Palatability, temperature of food ..... ____
    (4) Accuracy ..... ____

30. A time schedule for service of meals to patients and personnel should be established (to take care of traffic on the floors and elevators, staggering meal hours for employees, etc.) ..... ____

31. Establish a safety program in order that employees understand:
    (1) How to extinguish a grease fire ..... ____
    (2) Proper use of equipment guards ..... ____
    (3) Reporting accidents ..... ____
    (4) Hazard of slippery floors ..... ____

32. All sanitary facilities, including washrooms, are properly maintained ..... ____

33. Establish regular cleaning schedules and also provide for periodic sanitary inspections of dietary department:
    (1) Floors ..... ____
    (2) Utensils ..... ____
    (3) Machinery ..... ____
    (4) Equipment ..... ____
    (5) Cabinets ..... ____
    (6) Sinks ..... ____
    (7) Grease traps ..... ____

REFERENCES

"Food Service in Institutions," West and Wood; John Wiley and Sons, Inc., New York City, N. Y.

"Food Values of Portions Commonly Used," Bowes and Church; Anna dePlanta Bowes, 211 S. Juniper Street, Philadelphia 7, Pa.

"Care of Food Service Equipment," American Dietetic Association; Burgess Publishing Company, 426 S. Sixth Street, Minneapolis, Minn.

"Quantity Food Service Recipes," J. B. Lippincott Co., E. Washington Square, Philadelphia, Pa.

"A Handbook of Diet Therapy," The University of Chicago Press, Chicago, Ill.

"Ordinance and Code Regulating Eating and Drinking Establishments," Public Health Bulletin 280, U. S. Public Health Service, Washington 25, D. C.

"Guide to Safe Food Service," Andrews and Champion, U. S. Public Health Service, Washington 25, D. C.

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Service departments

Plant operation, maintenance and repair

We do not always give sufficient consideration to the very intimate relationship between the maintenance of physical facilities and the medical and nursing care of the sick. In too many instances the chief engineer or superintendent of service, while he may have the best of qualifications, is not permitted to play the important role that he should as the head of one of the major departments of the hospital.

It should be realized that the modern hospital, from a physical standpoint, is one of the most complicated building structures we have. Maintenance and operation of the physical plant constitutes a large item of the total expense of the hospital.

Thus, for reasons of economy and efficiency, as well as to insure total cooperation in the care of the sick, it is mandatory that this department be properly staffed and that its personnel be provided with adequate tools, equipment and supplies. There is no place in the hospital for the "baling wire" maintenance man.

1. Appoint a qualified chief engineer or service superintendent ..... ____
2. Chief engineer given status of head of a major department. All supervisory employees recognize the authority and responsibilities of the engineer..... ____
3. Under the supervision of the chief engineer may be the following:
   (1) The maintenance, repair and operation of all equipment, machinery and distribution lines concerned with the following:
      a. Steam and hot water..... ____
      b. Plumbing (including waste disposal) ____
      c. The electrical system (power and lighting, including emergency lighting) ..... ____
      d. Fire detection, prevention and fire fighting methods and devices..... ____
      e. Carpentry (including furniture repair) ..... ____
      f. Painting and decorating..... ____
      g. Vertical transportation equipment (elevators, dumb waiters)..... ____
      h. Communication and mechanical messenger systems ..... ____
   (2) Grounds maintenance and landscaping ____
   (3) Safety ..... ____
4. Purchase and installation of new plumbing, electrical or mechanical equipment for all departments to the extent that:
   (1) Requisitions are routed to the chief engineer for his comments..... ____
   (2) Installation is under the supervision of the chief engineer..... ____
5. Fuels are selected and purchased only after conference with the chief engineer..... ____
6. Chief engineer is the hospital fire marshal.... ____
7. Chief engineer is member of hospital safety board and safety inspection team..... ____
8. Chief engineer accompanies all outside inspectors when they make their rounds..... ____
9. Set up a work order system and provide centralized control over it. For example:
   (1) Only emergency jobs done without written work order. Written order follows ____
   (2) Chief engineer routes orders and makes follow-up ..... ____
   (3) Accurate cost records are maintained showing cost per job and cost per department ..... ____
10. Devices for effecting fuel economy are provided ..... ____
11. There are written preventive maintenance schedules for each piece of mechanical or electrical equipment ..... ____
12. Chief engineer instructs department heads in proper use of equipment to lessen maintenance costs ..... ____
13. The chief engineer consults with electric power company engineers periodically to ascertain that there is adequate illumination and power without waste..... ____
14. Equipment and supplies are standardized as much as possible so as to reduce inventories of repair and replacement parts..... ____
15. The chief engineer maintains the permanent files of manufacturers' operating and maintenance instructions and blueprints..... ____
16. There is an established routine for notifying each affected division of the hospital in advance of the voluntary suspension of any utility service ..... ____
17. The chief engineer maintains liaison with other engineers in the area (power plants, manufacturing and machine shops, etc.)..... ____
18. The chief engineer is provided with adequate office space and clerical assistance..... ____
19. Consider advantages and disadvantages of contract repair and maintenance service for such categories of equipment as elevators, office equipment, etc..... ____

Housekeeping

Good housekeeping is essential to the hospital in its role as a community service. Neatness and cleanliness affect all the people who use the hospital and boosts employee morale as well. Good housekeeping is part and parcel of good public relations.

To accomplish its total purpose, good housekeeping must be carried beyond the lobby. First impressions are important, of course, but it is the lasting impressions of

the patients which instill confidence in the hospital. A well-trained, competent housekeeper, able to organize the department into an efficient unit, is the key to economical operation. While the direct budget for housekeeping may be only three per cent of the total, other departments are helped to carry out their tasks more efficiently when full value is received for the dollars spent for housekeeping.

1. Appoint a qualified executive housekeeper _____
2. The housekeeper understands fundamentals of good personnel relations _____
3. Training programs are maintained for housekeeping service employees _____
4. Routine work schedules are coordinated with those of other departments _____
5. Supply centers are established for daily housekeeping supplies. There is a time schedule for issue of such supplies _____
6. In addition to follow-up of specific jobs, the housekeeper makes thorough periodic inspections, reporting to the chief engineer any maintenance defects observed _____
7. There is a concise schedule for the proper care of all floors, walls, furniture, windows, and equipment cared for by this department _____
8. The housekeeper advises on the selection of cleaning agents and other materials used by the housekeeping department _____
9. The housekeeper directs and supervises the use of selected materials for specific operations _____

Laundry

The purpose of the hospital laundry is to furnish clean linen in sufficient quantity. Clean linen has a good psychological effect on patients, makes them more comfortable and speeds their recovery.

The laundry is the largest user of heat, light, power, hot and cold water. For efficient operation, it should be located as close as possible to the power plant.

The laundry manager should be carefully chosen and his duties and responsibilities well defined. He should be thoroughly familiar with modern, efficient laundry operation and have a knowledge of machinery and chemistry as applied to the laundry process. Since this department must work closely with other departments of the hospital, it is of the utmost importance that the laundry manager should be a person who encourages cooperation.

1. Appoint a qualified laundry manager or supervisor _____
2. Studies are made of the causes of damage to linens (including unsightly stains) and methods of prevention are applied _____
3. Extremely soiled or contaminated linens are properly segregated from routine work _____
4. Special attention is given to linens for the nursery, operating and delivery rooms and similar areas _____
5. The laundry manager receives a copy of the daily census report _____
6. Periodic checks are made to determine the observance of proper washing formulae and wheel loadings _____
7. Install additional labor saving devices when the volume of work justifies the expenditure _____
8. Maintain system to routinely check volume and temperature of water and steam _____
9. Instruct all laundry personnel regarding the established policy relative to laundering of "nonhospital" work such as employees' personal clothing _____
10. Where the hospital will not operate its own laundry, contractual relations have been completed for commercial handling _____

REFERENCE

"Hospital Laundry Manual of Operation," American Hospital Association, 18 E. Division Street, Chicago 10, Ill., 167 pp.

Linen service

The linen service is frequently under the supervision of either the laundry manager or the housekeeper. When a central linen room is maintained, the housekeeper may be better able to handle this function; in decentralized systems the laundry manager may be the better choice.

The primary functions of the linen room are to supply linen when and where it is needed, to control the supply and to accomplish both most economically.

When it has been determined which type of service will be used, it is imperative to establish and adhere to a system which will ensure an adequate supply of linen. The seemingly small item of linen control in the hospital may mean the difference between a black and a red balance at the end of the year and between satisfied and dissatisfied patients and personnel.

1. Appoint qualified linen service manager _____
2. Linen management:
   (1) Linens are properly stored _____
   (2) There is adequate control over issues _____
   (3) All linens are properly and safely marked (including marking of date of original issue) _____
   (4) Excessive quantity of linens in nursing units is avoided _____
   (5) There is a system for the controlled issue of uniforms to employees _____
3. Full utilization of worn-out linens is made before their final discard _____
4. Distribution of linens is based upon actual requirements _____
5. Linen supervisor receives a copy of the daily census report _____
6. Adequate facilities and personnel are provided for the repair of linens _____
7. Hospital personnel are instructed in the proper use of various linens in order to minimize waste _____

REFERENCES

"Housekeeping Management and Organization," by Crete Dahl, The Dahls, Stamford, Conn.

"The Housekeeper's Handbook," by Stella E. Heinze, North Carolina Baptist Hospital, Winston-Salem, N. C.

"Hospital Laundry Manual of Operation," American Hospital Association, 18 E. Division Street, Chicago, Ill.

Additional information on laundry problems may be secured from the American Institute of Laundering, Joliet, Ill.

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Medical staff

The quality of patient care depends on the quality of individual members of the medical staff. The duty of primary importance to the governing board is the appointment of the medical staff. While the care of the sick may be considered the basic reason for being of the hospital, of practically equal importance to the welfare of the community are the research and educational contributions of the medical and allied professions. This is a moral obligation from which the good hospital does not attempt to escape.

The governing board faces a difficult task, particularly in the small community, in the selection of staff members. In addition to an examination of education, training, and experience and assurance that there will be conformity to the rules and regulations of the hospital, it is necessary that the board analyze the reputation and professional standing of potential staff members. Appraisal of individuals may be assisted by consultation with known reputable physicians of the area. The board usually has the authority, as shown by numerous court decisions, to select a staff which, in its best judgment, can assume professional responsibility for providing proper patient care. The hospital is not maintained primarily for the convenience of the medical staff.

Even the very small hospital requires some semblance of an organized medical staff. Morrill states that dissatisfaction has occurred in organizing medical staffs where proper balance was not maintained between the two major functions of the medical staff. The first function is that of advising the governing board in its formulation of policies and regulations relating to the professional care of the patient. The second is that of fostering within the staff a spirit of professional cooperation which will insure the highest grade of medical service to the patient and require a minimum of formal regulations by the governing board.

The staff is usually defined into two major groups. The active staff is composed of those who make most active use of the hospital. The visiting, or courtesy, staff are those who are less active but who are privileged to use the professional facilities of the hospital. The active staff is responsible for the preparation of medical policies. In cooperation with the governing board and the administrator, they usually assume responsibility for the care of the indigent patients. It is also their responsibility to participate in any educational programs undertaken by the hospital.

According to the size of the hospital and the qualifications of the staff members, there may be a separation into medicine, surgery, obstetrics, and specialty services. Even with a very small staff the group should be formally organized, with specific responsibilities designated to individuals or committees. These activities include intern and other educational activities, medical records including medical audit, pharmacy services, dietary services, executive committee and such other groupings as may be necessary to successful function.

Every hospital should offer at least the minimum in dental services, especially to care for emergencies. Whenever possible the installation of a complete dental service should receive serious consideration. In any event it is always advisable to have qualified dentists represented on the staff, for dental service in hospitals, a long neglected field, is rapidly assuming its proper role in national efforts to achieve the goal of better health.

Without dental services in hospitals, the patient cannot receive a complete diagnostic analysis of his condition. Total treatment cannot be accomplished, and potential causes of disability remain to permit future discomfort, illness, chronic diseases, and immeasurable economic loss. Oral surgery for repair of injuries and for eradication of infections of dental origin requires the services of a competent dental staff.

All hospitals may not need extensive facilities and equipment for complete dental services. If competent consultation is available in every hospital, much of the actual treatment, including surgical procedures, may be more economically furnished elsewhere. This can be done through an efficient integration and coordination of hospital activities, through health clinics, by group or private practitioners. Such methods must be determined and applied in the light of local needs and policies by combined efforts of leaders in the medical, dental and hospital fields.

1. There is an organized medical staff..... ____
2. There are formal by-laws, rules, regulations ____
3. The by-laws, rules, regulations are signed by all staff members..... ____
4. All physicians submit written application for appointment (showing training and experience) to the hospital administrator who submits them to the credentials committee of medical staff. Final approval is by the governing board ..... ____
5. Staff organization officers are elected by staff and approved by governing board..... ____
6. The staff is headed by a chief, president or chairman ..... ____
7. Essential committees are appointed (executive, credentials, medical records, program, etc.) ..... ____
8. Staff meetings are held at least monthly and each staff member must attend at least 75 per cent of those scheduled..... ____
9. Adequate records are kept of staff meetings ____
10. Clinical departmental meetings are scheduled at definite intervals..... ____
11. There is active departmentalization (medicine, surgery, obstetrics and gynecology, etc.) with each division headed by a chief of service ..... ____
12. Privileges and duties within the various clinical services are based upon the qualifications of the individual staff member..... ____
13. There are additional qualifications for the practice of surgery and the specialties..... ____

14. There is liaison between the medical staff, administration and governing board. Clinical departments, such as the nursing service, are given an opportunity to present and discuss mutual problems ..... ____
15. The administrator attends staff meetings..... ____
16. There shall be periodic medical audits by competent persons to determine the quality of professional care being rendered..... ____

Note: Throughout the body of this publication, whenever a statement refers to "medical staff," "physician," "surgeon," etc. it is to be remembered that, in like manner, it similarly pertains to dentistry and oral surgery.

REFERENCE

"Manual on Hospital Standardization" (American College of Surgeons, 40 E. Erie Street, Chicago 11, Ill.

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Medical records

"In accordance with up-to-date hospital and medical practice, medical records are indispensable from the standpoint of the patient, the hospital, the physician, medical research, and the legal aspect.

"As medical records relate to the patient, every illness, even though of a minor character, involves study and examination to the extent that it is impossible for any individual to keep all this detail in mind; the written record, then, is evidence that the patient's case is being handled in a systematic and intelligent manner. Also, the patient may be readmitted with the same or another illness to the same or to another hospital, and another physician may be called in attendance. The medical record of the former hospitalization, if accurate and complete, will be useful to the patient in any future illness. Some examinations need not be repeated and at times dangers are indicated which may be avoided. Complete medical records will often facilitate prompt and proper care of patients, a factor which may determine life or death.

"From the standpoint of the hospital, the medical record is a document of facts which contains statements by trained observers of conditions found and results of treatment, and which indicates whether or not the efforts of its physicians supplemented by hospital facilities are in accordance with reasonable expectations of present day scientific medicine. A medical record is in fact a case study. The hospital is responsible for the results of its service, and only from the medical records can there be made an analysis of the immediate results, the reasons therefore, and the quality and quantity of work done.

"From the legal aspect, the medical record is of great value, both to the physician and the hospital. The position of both is strengthened by the record which was written at a time when there was no thought of legal action."

(From the *Manual of Hospital Standardization*, American College of Surgeons, 40 E. Erie Street, Chicago 11, Ill.)

1. Appoint a qualified medical record librarian ____
2. If no qualified medical record librarian is available, appoint and train a medical record clerk. Consider the services of a consulting medical record librarian..... ____
3. Maintain medical records in such a manner that:
   (1) Medical audits are readily accomplished ____
   (2) Comparison may be made with similar institutions ..... ____
4. There is an active, informed and interested medical record committee of the medical staff and it receives the full support of the staff, the governing board and the administration ..... ____
5. The work of the various medical services is reviewed and analyzed at staff meetings. The relationship between clinical and pathological diagnosis is studied by the staff..... ____
6. An accepted system of medical nomenclature and classification is adopted (Recommended: Standard nomenclature of Disease and Standard Nomenclature of Operations)..... ____
7. The medical staff codes its findings according to the adopted nomenclature..... ..... ____
8. There is an accepted system for the filing and storage of medical records..... ____
9. Physical facilities are adequate..... ..... ____
10. There are the following cross-index systems:
    (1) By patient ..... ____
    (2) By physician ..... ____
    (3) By operation .... ____
    (4) By disease .... ____
11. Records are written promptly after the patient is admitted..... ____
12. Physicians are not permitted to become delinquent in the completion of medical records ..... ____

Note: This will require the installation of a very definite system strongly backed up by the governing body, medical staff and administration.

13. Only members of the medical staff are charged with the responsibility for recording patients' histories, progress notes, medication and treatment orders and final dis-

charge notes ..... ____

14. All records are signed by the physician..... ____
15. All records show admitting or provisional diagnosis and prognosis as well as final diagnosis ..... ____
16. The status of the medical records as "privileged communications" is fully understood by all personnel who may have access to them ..... ____
17. Medical records are available to the medical staff for group studies..... ____
18. The medical record contains the following clinical information (ref.: "Printed Forms Check List"):
    - (1) Identification data ..... ____
    - (2) Patient's complaint ..... ____
    - (3) Present illness ..... ____
    - (4) Past history ..... ____
    - (5) Family history ..... ____
    - (6) Physical examination (including oral health) ..... ____
    - (7) Laboratory reports ..... ____
    - (8) Consultations ..... ____
    - (9) X-ray reports ..... ____
    - (10) Provisional diagnosis ..... ____
    - (11) Tissue reports (gross and microscopic) ____
    - (12) Treatment (medical and surgical) including physician's orders..... ____
    - (13) Final diagnosis ..... ____
    - (14) Condition on discharge..... ____
    - (15) Autopsy findings ..... ____
19. The medical record librarian consults with other department heads regarding the format and contents of departmental clinical records, including monthly and yearly statistical reports ..... ____

Note: The medical records librarian will be able to furnish valuable information regarding the proper methods and responsibility involved in the reporting of communicable diseases, births, stillbirths, deaths, and other information which may be required by regulatory agencies.

REFERENCES

"Manual for Medical Records in the Hospital"—Edna K. Huffman, The Physicians Record Co., Chicago, Ill.
"Clinical Records in the Hospital"—Malcolm T. MacEachern, M.D., The Physicians Record Co., Chicago, Ill.
"Manual on Hospital Standardization"—The American College of Surgeons, Chicago, Ill.

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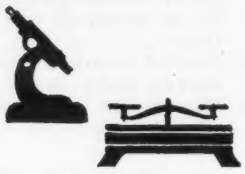
Other professional services



Radiology

The practice of modern medicine and surgery has increased the use of the specialized departments in the hospital, such as radiology. For both diagnosis and therapy the x-ray department gives valuable service in providing complete medical care to the patient.

The following basic guides will be helpful in providing efficient x-ray service to the patient.

Proper supervision, adequate personnel and sound administrative policies are essential for a well-organized x-ray department.

1. Arrange for services of fulltime, part-time or consulting radiologist ..... ____
2. If only consulting radiologist is employed, appoint a qualified physician to supervise the radiology department. All films should be reviewed and interpreted by the consulting radiologist ..... ____
3. Employ adequate staff of qualified technicians to provide fulltime coverage ..... ____
4. Secure report from qualified inspector showing that all personnel are properly protected from danger of electrical shock, mechanical or irradiation injury ..... ____
5. Provide for proper protection of all film from irradiation damage ..... ____
6. Establish uniform request and report system ____
7. All reports are written in duplicate, original signed by radiologist and placed in patient's record. The department retains sufficient copies to maintain cross-index by type of examination and name of patient ..... ____
8. Reports (monthly, yearly and as required) are compiled by type of examination and treatment ..... ____
9. Only fully qualified *radiologists* administer x-ray therapy ..... ____
10. Chief of x-ray recognized as the head of a major clinical department ..... ____
11. Consideration is given to the taking of routine chest plates on all patients newly admitted to the hospital ..... ____
12. There is an approved system for the filing and storage of x-ray films (including dental) ____
13. Establish uniform techniques ..... ____
14. Proper precautions are observed in the storage, handling and use of radium and radioisotopes ..... ____

REFERENCES

"A Manual of Desirable Standards for Hospital Radiological Departments." The American College of Radiology, 20 N. Wacker Drive, Chicago 6, Ill.

"Manual of Hospital Standardization." The American College of Surgeons, 40 E. Erie Street, Chicago 11, Ill.

"Medical Diagnostic Services for Small Communities." The W. K. Kellogg Foundation, Battle Creek, Mich.

Clinical laboratory

The clinical laboratory service is one of the basically essential adjunct services of the hospital.

Through years of use and evaluation, many laboratory tests have become accurate and necessary tools for confirming the diagnosis of certain diseases. Effective application of chemotherapy in treatment of disease requires knowledge of the causative organism. Pathological examination of tissues removed at operations and post-mortem examinations provide essential information on the changes which take place within our bodies. Extensive use of whole blood and plasma has made it necessary for all hospitals to provide this service to their patients. The importance of the clinical laboratory cannot be overestimated, and its use by the medical staff is an indication of thorough diagnostic procedure.

The following activities are listed to provide guideposts to assist in finding solutions to problems of policy and administration.

1. Arrange for services of fulltime, part-time or consulting pathologist ..... ____
2. If only consulting pathologist is employed, appoint qualified local physician to supervise the laboratory ..... ____
3. Employ adequate staff of qualified technicians to provide fulltime coverage ..... ____
4. Provide that tests in the following categories be done locally or in an expeditious manner by outside laboratories:
   (1) Gross and microscopic examination of tissues ..... ____
   (2) Bacteriology ..... ____
   (3) Parasitology ..... ____
   (4) Hematology ..... ____
   (5) Chemical and morphologic examination of other body fluids, exudates, transudates and excreta ..... ____
5. Obtain the necessary certificates from state board of health for the performance of premarital and prenatal syphilis serology tests ____
6. Establish, in agreement with medical staff, what "routine" laboratory procedures will be done when patients are admitted ..... ____
7. Establish policies regarding laboratory work for outpatients or on specimens sent in by physicians outside of the hospital ..... ____
8. Establish uniform system of records and reports: ..... ____
   (1) Written requests for laboratory tests ..... ____
   (2) Examination reports provide for the signed original to be firmly fixed in patient's clinical record. Sufficient copies are filed in laboratory according to name of patient and type of examination ..... ____
   (3) Monthly and yearly summary reports of specimen and examination type ..... ____
9. Personnel authorized to originate laboratory requests ..... ____

10. Personnel authorized to procure specimens.... _____
11. Collection, delivery and delivery time of specimens (to laboratory)..... _____
12. Continuous liaison is maintained between laboratory personnel and medical staff to insure that satisfactory service is being rendered ..... _____
13. All tissues removed at operation are examined by the pathologist (whose report is entered in the patient's clinical record)..... _____
14. Chief of laboratory service is recognized as the head of a major clinical department and participates in medical staff conferences..... _____

REFERENCES

"Manual of Hospital Standardization." The American College of Surgeons, 40 E. Erie Street, Chicago 11, Ill.
"Medical Diagnostic Services for Small Communities." The W. K. Kellogg Foundation, Battle Creek, Mich.
"The Hospital Laboratory." Division of Hospital Facilities, Public Health Service, Federal Security Agency, Washington 25, D. C.

Hospital pharmaceutical service

Approximately five per cent of the total annual expenditures of hospitals go for pharmaceutical service. This figure alone emphasizes the need for a careful analysis by the administrator to foster economies. That a hospital pharmacy with a well qualified hospital pharmacist in charge is a necessity has been accepted by the larger hospitals. Small hospitals have not all taken this position, largely because of the fear of increasing their operating deficits.

However, if the advantages to the hospital are clearly understood by both administrators and boards of trustees and if more efficient operations will result in better services or savings, the advantages to hospital administration, physician and patients should be worth the effort.

Hospitals which fail to employ a pharmacist with proper training, experience and talent are seriously lowering the efficiency of their services and operations. A well-organized pharmacy will function in its own right and also contribute to the whole integrated hospital organization. Employment of a fulltime pharmacist, even in a hospital of moderate size, far from being an exorbitant expense, will more than pay for itself through collateral savings.

1. Appoint a full or part-time qualified, licensed pharmacist (preferably one experienced in hospital pharmacy operation)..... _____
2. Consider the appointment of a pharmacy advisory committee consisting of the pharmacist, the administrator and elected members of the medical staff..... _____
3. *Establish policies and procedures relative to:*
   (1) Installation of a hospital formulary..... _____
   (2) Selection of pharmaceuticals to be stocked in the various nursing units and treatment areas..... _____
   (3) Restricted use of certain preparations _____
   (4) Extent to which pharmacist will prepare and sterilize certain injectible medications (including parenteral fluids) _____
   (5) Extent to which pharmacist will manufacture pharmaceuticals ..... _____
   (6) Dispensing of drugs, chemicals and pharmaceuticals ..... _____
   (7) Approved system for the control of narcotics and barbiturates..... _____
      a. Storage facilities burglar-proof..... _____
      b. Adequate receiving and issuing records ..... _____
      c. Adequate records of consumption..... _____
   (8) Procurement, storage and use of tax-exempt alcohol ..... _____
   (9) Role of pharmacist in education of medical and nursing staffs (in relation to new preparations, etc.)..... _____
   (10) Purchase of pharmaceuticals (see also "Purchasing and Stores Control"):
      a. Specifications for pharmaceuticals are provided by the pharmacist, and
      b. Request for purchase (showing these specifications) sent to purchasing agent for placement of order; or
      c. Pharmacist is appointed assistant purchasing agent in charge of purchase of pharmaceuticals..... _____
   (11) Adequate system of general records:
      a. Inventory and cash controls are maintained ..... _____
      b. Approved requisition required prior to issue of pharmaceuticals to any nursing or treatment area..... _____
      c. Maintenance of prescription files (in accordance with accepted practices) _____
      d. System for recording charges to patients (in accordance with instructions of administrator)..... _____
   (12) Sales to the lay public (other than patients) ..... _____
   (13) Sales to employees..... _____
   (14) Sales to medical staff..... _____
   (15) Disposition of partially consumed prescriptions issued for patients..... _____

REFERENCES

"Manual of Hospital Standardization," American College of Surgeons, 40 E. Erie Street, Chicago 11, Ill.
"Minimum Standards for Hospital Pharmacies," American Society of Hospital Pharmacists, 2215 Constitution Avenue, N. W., Washington 7, D. C.
"The Hospital Pharmacy," Division of Hospital Facilities, Public Health Service, Federal Security Agency, Washington 25, D. C.

Hospital drug room

(For Hospital Without a Pharmacist)

1. Delegate a physician to supervise the operation of the drug room and to give advice on pharmaceutical problems ..... _____
2. Arrange for service of a *consulting* pharmacist ..... _____
3. Establish policies and procedures relative to:
   (1) Specifications for the purchase of all pharmaceuticals[1] ..... _____
   (2) Filling and labelling of all containers of pharmaceuticals ..... _____
   (3) Frequency of periodic inspection of pharmaceuticals stocked by the various divisons of the hospital..... _____
   (4) Method of administering a charge system for supplies..... _____
   Note: The following are examples of methods generally adopted:
      a. Charges to inpatients:
         1. All-inclusive rate ..... _____
         2. Partially inclusive rate (for example: No charge for U.S.P. and N.F. drugs) ..... _____
         3. Flat charge, regardless of length of stay ..... _____
         4. Charge for each unit of service (i.e., cost plus)..... _____
      b. Charges to outpatients:
         1. At cost ..... _____
         2. Cost plus ..... _____
         3. List price ..... _____
         4. Free ..... _____
   (5) Periodic physical inventories..... _____
   (6) Development of a basic formulary..... _____
      a. List of stock pharmaceuticals..... _____

[1]The reprints "The Hospital Pharmacy Equipment and Supply List" and "The Twenty-five Bed Hospital, Suggested Planning and Equipment" (Federal Security Agency — Public Health Service) include a list of pharmaceuticals by size and quantity and indicate specifications and special storage conditions where necessary.

b. Sizes and quantities..... ——

(7) Purchase and control of narcotics and barbiturates[2] ..... ——

a. Storage facilities burglar-proof..... ——

b. Adequate receiving and issuing records ..... ——

c. Adequate records of consumption..... ——

(8) Procurement, storage and use of tax-exempt alcohol[3] ..... ——

(9) Determination of pharmaceuticals to be stocked in nursing units, emergency room, etc. (including antidotes in emergency room) ..... ——

(10) Determination of sources of supply and procedures in purchasing (see also "Purchasing and Stores Control"). For example: ..... ——

a. Stock pharmaceuticals ..... ——

1. Direct purchase from wholesaler or manufacturer, or..... ——

2. Contract through local pharmacy ——

Note: In some states several preparations, notably certain biologicals, may be available through the state board of health ..... ——

(11) Handling of prescriptions for private patients ..... ——

(12) Frequency of inspection for deteriorated, overstocked or obsolete preparations..... ——

a. Secure permission of vendor to return, for replacement or credit, all intact containers ..... ——

b. Destroy all opened containers of deteriorated or obsolete preparations.... ——

[2]Apply to nearest Regional Office, U. S. Treasury Department, Bureau of Narcotics, for a copy of "Regulation Number 5."

[3]Apply to nearest Regional Office, U. S. Treasury Department, Bureau of Internal Revenue, for a copy of "Regulation Number 29."

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Nursing service

Administration

The nursing department, delegated with responsibility for patient care, must be ready for action when the first patient is admitted. The favorable or unfavorable reaction of a patient and his family to hospitalization will to a great extent be influenced by the "readiness for response" of the nursing staff to patient needs and requests.

The accompanying list of activities is not intended to be all-inclusive. It attempts to be a guide to assist a qualified nurse-administrator in checking the preparation made by her and her staff in order to be in a state of "readiness to serve."

Perhaps no other single department in a hospital has ramification to as many other departments as nursing. Some of these activities indicate the interdepartmental policy forming committees which will be needed if a functioning organization for good patient care is to be in operation both when the first patient is admitted and thereafter.

1. Appoint qualified nursing service director.... _____
2. Develop and distribute to all applicable departmental personnel written nursing service policies and procedures.... _____
3. Determine that all nursing service personnel fully understand the administrative policies of the hospital relative to the release of information about patients or hospital activities .... _____
4. Provide for organization of the nursing service on a functional basis (i.e., job to be done, who is to do it, and their qualifications)..... _____
5. Establish written qualifications for all nursing service personnel, both professional and nonprofessional .... _____
6. Determine, on a basis of job assignment, the responsibilities and duties of all personnel.... _____
7. Determine the total number of full and part-time professional and nonprofessional personnel required for each area at all times.... _____
8. Determine policies governing the utilization of both professional and nonprofessional special nurses in private practice.... _____
9. Consider an inservice training program for all nursing service personnel.... _____
10. Ascertain that all inpatient units are completely set up and ready for use, including:
    (1) Furniture, i.e., patients' rooms and nursing service areas.... _____
    (2) Linens, pillows, blankets and utensils for patient care.... _____
    (3) Drugs, medications, solutions and equipment for their administration.... _____
    (4) Treatment trays and other clinical equipment, or provision for obtaining such from the central supply room.... _____
    (5) Records, forms and office supplies (see "Printed Forms" and "Medical Records") .... _____

General policies and procedures

Establish written policies and procedures relative to:

11. Environmental conditions in nursing units and treatment areas.... _____
    (1) Regulation of temperature, humidity, ventilation and lighting.... _____
    (2) Methods of routine and special cleaning, and the disposal of waste.... _____
12. Admission of patients to *nursing units*.... _____
    (1) Notification to physician, business office and other essential areas.... _____
    (2) Disposition of clothing and valuables.... _____
    (3) Provision of clothing by hospital or patient during hospitalization.... _____
13. Discharge of patient from *nursing units*.... _____
    (1) Notification of business office and other designated offices .... _____
    (2) Return of patient's clothing and valuables .... _____
    (3) Release of patient against medical advice _____
    (4) Referral to proper health agency or organization as necessary.... _____
14. Procedures (nursing and medico-administrative) following death.... _____
15. Control and management of communicable, infectious and suspect diseases.... _____
16. Routines for supportive care.... _____
17. Administering the approval policy for control of narcotics, hypnotics, poisons and the use, care and control of radioactive substances .... _____
18. Written, verbal and standing orders by the medical staff and the conditions under which specific personnel are authorized to receive and carry out such orders.... _____
19. Missing patients .... _____
20. Visits by clergy and use and care of articles for religious purposes.... _____
21. Control of fire, burns and explosion hazards in the use of oxygen and therapy gas equipment, electrical appliances (fans, radios, inhalators, heating pads) and hot water bottles _____
22. Use of restraints.... _____
23. Medications brought by patient to hospital _____
24. Transfer and transportation of patients between departments .... _____
25. Notifying administration in event of hospital-incurred infections .... _____
26. Degree of nursing service responsibility for food service and housekeeping.... _____
27. Responsibilities of nursing service for health teaching of the patient.... _____
28. Operation of the nursing service in the event of disaster .... _____
29. Care of the disturbed or irresponsible patient _____
30. Care of patients in shock, hemorrhaging or other serious conditions.... _____
31. Notification of family, clergy, physician and

others as necessary in event of emergencies, including the critically ill ____

32. Furnishing equipment and supplies for home use of patients (such as orthopedic, nursery, surgical, etc.) ____
33. Physical examination before assignment to duty and frequency of periodic health inspection, including nose and throat cultures, for all nursing personnel ____
34. Records and forms (see "Printed Forms"), such as:
    (1) Daily time—assignment records ____
    (2) Medication and treatment forms, cards, etc. ____
    (3) Daily nursing service reports of patient's condition and pertinent events ____
    (4) Nursing unit census reports ____
    (5) Notice of discharge ____

Central supply room

Establish written policies and procedures relative to:

1. Designation of qualified supervision ____
2. Type and extent of service ____
    (1) Sterile equipment and supplies to patient areas ____
    (2) Service provided to special departments, operating room, delivery room, emergency room, other ____
    (3) Special equipment such as suction, oxygen therapy, side rails, orthopedic ____
    (4) Outside of hospital (to agencies or individuals) ____
    (5) 24-hour service ____
3. Requisitioning, issuing, control and charging of supplies and equipment ____
4. The establishment, enforcement and checking of aseptic techniques, including sterilization procedures and equipment ____
5. The assembling, care, repair and replacement of clinical supplies and equipment ____
6. Persons permitted in central supply room and type of clothing to be worn by them ____
7. Routine cleaning ____
8. Staffing, including emergency coverage ____
9. Central supply room set up and ready for use, including: ____
    (1) All central supply room equipment, i.e., water still, sterilizers, special cleaning apparatus, etc. ____
    (2) Sterile or nonsterile sets and trays, i.e., blood transfusion, intravenous, paracentesis, aspirating, dressing, irrigation, tracheotomy, catheterization, enemata, syringes, needles, gastric drainage, gastric irrigation and lavage, spinal, suture removal, surgical preparation, burns, etc. ____
    (3) Sterile supplies, i.e., dressings, gloves, packing, syringes, needles, towels, intravenous and irrigating solutions, applicators, gowns, rubber tubing, etc. ____
    (4) Emergency equipment, i.e., aspiration, drainage and suction apparatus, oxygen administration, bed cradles, heating pads, bed rails, portable suction, etc. ____
    (5) Unsterile supplies, i.e., adhesive, bandages, etc. ____
    (6) Special supplies for operating room, delivery room, and emergency room, etc. ____
    (7) Cleaning supplies and equipment pertinent to the department ____
    (8) Requisition forms ____

REFERENCES

Barrett, Jean, "Ward Administration and Teaching." Appleton Century Crafts, Inc., New York, 1949.

Randall, Margaret, "Ward Administration," W. B. Saunders Company, Philadelphia, and London, 1949.

Harmer, Bertha, and Henderson, Virginia, "Textbook of the Principles and Practice of Nursing." The MacMillan Company, New York, fourth edition revised, 1939.

"Staffing the General Hospital—25 to 100 Beds," Federal Security Agency, Public Health Service, Division of Medical and Hospital Resources and Division of Hospital Facilities, Washington 25, D. C., 1949.

"Hospital Nursing Service Manual," published by National League of Nursing Education, 1790 Broadway, New York 19, N. Y., 1950.

Underwood, Weidan B., "A Textbook of Sterilization," American Sterilizer Company, Erie, Pa., 1942.

Emergency room

Establish written policies and procedures relative to:

1. Responsibility for supervision and staffing ____
2. Extent and type of service:
    (1) 24-hour coverage ____
    (2) Use by medical staff for private patients ____
    (3) Restricted use of anesthesia ____
    (4) Professional procedures (limitations of, etc.) ____
3. Carrying out established administrative policies:
    (1) For charges to patients ____
    (2) For cash handling ____
    (3) For immediately reporting all pertinent medico-legal cases to the proper police agency ____
    (4) For release of information about patients ____
4. Record and report system, including medical records, special reports for accidents, charges, etc. ____
5. Notification of family and others as necessary ____
6. Referral of patients to other agencies as necessary ____
7. Emergency room set up and ready for use, including:
    (1) All furniture and special equipment, i.e., examining table, instrument tables, irrigating stands, lamps, stretcher, and wheelchair ____
    (2) Drugs, medications, anesthetic agents, and equipment for their administration, i.e., antiseptics and disinfectants, cardiac and respiratory stimulants, poison antidotes, parenteral fluids, plasma and blood (or provision for) ____
    (3) Sterile supplies and equipment, i.e., dressings, sponges, applicators, instruments, needles, sutures, drains, syringes, gastric lavage ____
    (4) Unsterile supplies, i.e., bandages, adhesive, splints, material for plaster casts, hot water bottles, etc. ____
    (5) Physical examination equipment, i.e., blood pressure, percussion hammers, ophthalmoscope, oral health examination equipment, etc. ____
    (6) Records and forms (see "Printed Forms") ____
    (7) Linens, blankets, pillows ____
    (8) Emergency dental equipment ____

Operating suite

Establish written policies and procedures relative to:

1. Designation of qualified operating room supervisor ____
2. Responsibilities of nurse supervisor, surgeons, anesthesiologists, etc. ____
3. Scheduling of routine and emergency operations ____
    (1) Maintaining list of surgeons (and oral surgeons) who may use the operating room and for what type of surgery ____

(2) Persons who may assist surgeons..... ____
(3) Persons who may administer anesthesia and types of anesthesia..... ____
(4) Persons who may enter the operating room area ..... ____

4. Clothing of all persons in the operating room ..... ____
5. Control of special temperature and humidity requirements ..... ____
6. The care, repair, and replacement of instruments and equipment owned by hospital and private physicians ..... ____
7. Staffing, including emergency coverage..... ____
8. The establishment, enforcement and checking of aseptic techniques including sterilization procedures and equipment..... ____
9. The care and disposition of routine and special laboratory specimens, such as tissues, fluids, blood, etc..... ____
10. The use, care and disposition of radioactive substances ..... ____
11. The services of the central supply room for operating room supplies..... ____
12. Selection, use and accounting of sponges and packs ..... ____
13. Routine cleaning of the operating room and special cleaning following septic operations or infectious patients..... ____
14. The establishment and enforcement of approved methods for the control of explosion hazards (proper storage and use of anesthetic agents, medications, instruments and other supplies and equipment including devices for control of static electricity)..... ____
15. Operating room suite set up and ready for use, including:
    (1) All furniture and special equipment, i.e., operating room tables, instrument tables, irrigating stands, basin stands, lamps, cautery, suction apparatus, and electrosurgical machines ..... ____
    (2) Anesthetic gases, drugs and equipment for administration, i.e., inhalation, intravenous, spinal, local and rectal..... ____
    (3) Drugs, medications, i.e., parenteral fluids and equipment for their administration, antiseptics and disinfectants, narcotics, cardiac and respiratory stimulants, and provision for whole blood and plasma..... ____
    (4) Sterile supplies, i.e., basins, brushes, catheters, drains, dressings, sponges, packs, gloves, drapes, sheets, towels, gowns, aspirating and luer syringes, suture and luer needles, sutures, water, saline, boric, instruments (sterile or checked; ready for sterilization)..... ____
    (5) Materials for plaster casts, i.e., plaster of paris bandages, felt, stockinett or sheet wadding ..... ____
    (6) Sheets, pillow slips, blankets, binders, gowns, caps and masks..... ____
    (7) Adhesive plaster and bandages..... ____
    (8) Cleaning supplies and equipment..... ____
    (9) Records and forms (see "Printed Forms") ..... ____
        (a) Operation schedules and reports..... ____
        (b) Individual operation and anesthesia record ..... ____
        (c) Operation and anesthesia charge slips ..... ____
    (10) Dental operating facilities set up and ready for use..... ____

REFERENCE

"Recommended Safe Practice for Hospital Operating Rooms," NFPA. No. 56, adopted by National Fire Protection Association, American Hospital Association and National Board of Fire Underwriters, 1949. National Fire Protection Association (International) 60 Batterymarch Street, Boston 10, Mass.

Maternity unit

Establish written policies and procedures relative to:

1. Designation of a qualified nurse supervisor for the maternity unit..... ____
2. Segregation of obstetrical patients, personnel and facilities from all others in the hospital ____
3. Physical examination before assignment to duty and frequency of periodic health inspection, including nose and throat cultures, for all obstetrical division personnel..... ____
4. Availability of obstetricians at all times..... ____
5. Newborn accommodation (Infant to remain with mother or be placed in nursery?)..... ____
6. Prenatal determination of Rh factor, existence of tuberculosis and venereal disease.... ____
7. Medical consultation for:
    (1) Patients in labor 24 hours or more..... ____
    (2) For major or complicated obstetrical procedures ..... ____
    (3) Therapeutic abortions ..... ____
8. Management of maternity unit in the presence of communicable disease, infection and suspect cases (segregation of patients during labor, delivery and post-partum care, etc., from other maternity patients)..... ____
9. Visitors ..... ____
    (1) Labor room ..... ____
    (2) Delivery room ..... ____
    (3) Nurseries ..... ____
    (4) Post-partum areas ..... ____
10. Protection of infant and mother from infection ..... ____
11. Special and routine care:
    (1) Observation for post-partum hemorrhage ..... ____
    (2) Ante-partum, labor, delivery..... ____
12. Admission and accommodation for mother and infant when delivery occurs outside of maternity unit ..... ____
13. Prompt completion and submission of birth certificates, through proper administrative channel, to the appropriate governmental agency ..... ____

Labor rooms

14. Persons authorized to make ante-partum examination (physicians or nurses)..... ____
15. Maintenance of medical records of the patient's progress while in labor..... ____

Delivery room

16. Necessary authority and responsibility for administration of anesthesia..... ____
17. Appropriate clothing of *all* persons who enter the delivery room (such as gown, cap, and masks) ..... ____
18. Permit for surgical intervention of any type ____
19. Responsibility and methods for immediate routine care, handling, resuscitation, etc., of newborn infant while in the delivery room. The importance of an adequate oral inspection cannot be over-emphasized..... ____
20. Maintenance of medical records of mother and infant while in delivery room..... ____
21. Safe, proper and adequately secured identification of infant..... ____
22. Administration of prophylactic treatment to infant's eyes ..... ____
23. Collection, examination and disposition of specimens, such as placental tissue, blood, etc. ..... ____
24. Handling and disposition of dead fetus and stillborn infants ..... ____
25. Provision for transfer of newborn infants from delivery room to infant area in heated bassinet or other indicated device..... ____
26. Control of special temperature and humidity requirements ..... ____

27. Routine and frequency of cleaning delivery room and special cleaning following delivery of infectious patient _____
28. Delivery and labor room setup and ready for use, including:
    (1) Furniture, i.e., bed, bedside tables, chairs, side rails, delivery table, instrument table, basin stands, irrigating stands, anesthetic table, lamps, suction apparatus, resuscitating apparatus, stretcher, incubators, heated bassinets, standard bassinets, stools, etc. _____
    (2) Anesthetic gases, and drugs and equipment for their administration, i.e., inhalation, spinal, caudal _____
    (3) Medications, solutions, pharmaceuticals, i.e., cardiac and respiratory stimulants, drugs to control hemorrhage, parenteral solutions, plasma and provision for blood, antiseptics and disinfectants _____
    (4) Sterile supplies, i.e., basins, brushes, catheters, syringes, pads, dressings, drapes, sheets, towels, gowns, gloves, sutures, needles, water, instruments _____
    (5) Sheets, pillow slips, blankets, binders, gowns, caps, and masks _____
    (6) Preparation trays _____
    (7) Records and forms _____
    (8) Waste basins _____
    (9) Cleaning equipment and supplies _____

Nursery for newborn infants

29. Control of temperature, humidity, and ventilation _____
30. Only authorized medical staff members and employees may enter nursery and then only when properly clothed (i.e., cap, mask, gown) _____
31. Supervision of private practice nurses _____
32. Routine to be instituted in the event of outbreak of diarrhea, other infection or suspect cases. For example:
    (1) Removal of "suspect" infant to precaution or isolation room _____
    (2) Closing nursery _____
    (3) Transfer of infants _____
    (4) Admission of other infants _____
    (5) Notification to official health agency (through proper administrative channel) _____
33. Routine and frequency of cleaning occupied nursery areas and infants' individual units following discharge _____
34. Observation of nursery activities at all times _____
35. Observation and care of infants _____
    (1) Initial examination (including oral inspection) _____
    (2) Technique for individual care _____
    (3) Special and routine care of skin, umbilical cord stump and oral abnormalities _____
    (4) Feeding _____
    (5) Transporting to mother _____
    (6) Examination on discharge _____
36. Premature infants:
    (1) Routine and special treatment _____
    (2) Care and feeding _____
    (3) Referral to proper health agency _____
    (4) Preparation for home care _____
    (5) Transportation _____
    (6) Return visits, etc. _____
37. Infants' clinical charts, work records, and formula prescriptions _____
38. Infants' linens, including clothing _____
    (1) Supplying, laundering and sterilization _____
    (2) Handling and disposal of soiled diapers _____
39. Ritual circumcision _____
40. Disposal of identification beads or similar devices upon discharge of infant _____
    (1) Sold or given to family or retained by hospital _____
    (2) Removal from infant in presence of parent _____

REFERENCES

"Standards and Recommendations for Hospital Care of Newborn Infants—Full—Term and Premature," Bureau Publication 292, U. S. Department of Labor, Children's Bureau.
"Hospital Care of Maternity Patients," U. S. Department of Labor, Children's Bureau, Publication No. 314.

Formula room

Establish written policies and procedures relative to:

1. Assignment of qualified personnel under proper supervision _____
2. Restriction of traffic and visitors _____
3. Equipment (plus special equipment for infants with abnormal conditions), i.e., bottles, nipples, etc. _____
    (1) Supply for each infant for 24-hour period _____
    (2) Return, cleaning and care _____
4. Preparation, handling and storage of formula, feedings and water _____
    (1) Terminal sterilization or aseptic technique _____
    (2) Refrigeration _____
    (3) Distribution _____
    (4) Periodic bacteriological examinations and check of sterilizers _____
    (5) Proper clothing of personnel _____
5. Records (see "Printed Forms") _____

REFERENCE

"Procedures and Layout for Infant Formula Room," American Hospital Association, 1949.

Pediatrics unit

Establish policies and procedures relative to:

1. Age of children admitted to this unit _____
2. Segregation of all children _____
    (1) From adults _____
    (2) By sex, age and type of illness _____
3. Bringing of toys, food, etc., to children _____
4. Observation of all children for designated period following admission _____
5. Giving the child maximum freedom for normal activity when medically feasible _____
6. Visiting and overnight stay by parents _____
7. Special pediatric records (see "Printed Forms") _____

REFERENCE

"A Study of Nursing Service in One Children's and Twenty-one General Hospitals," National League of Nursing Education, 1790 Broadway, New York 19, N. Y., 1948.

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Standing orders

In his book, "Hospital Organization and Management" (Physicians Record Company, Chicago) Dr. Malcolm T. MacEachern states:

"In order to promote efficiency and economy in the hospital, it is advisable to systematize and standardize procedures and relationships insofar as this can be done, avoiding, however, that extreme routine which does not recognize individuality.

"Standing orders are of two types, viz.: Administrative, referring to departmental relationships; and professional, dealing with technique and duties in the care of the patient."

Before becoming effective such orders should be approved by the administrator of the hospital.

The following list is suggestive of the types of standing orders which may be required by a hospital. Their composition would, of course, be dependent upon the policies and procedures of the individual hospital.

List of standing orders

Administration and general

1. Policy regarding visiting hours ____
2. Routine for handling incoming and outgoing official mail. Same for patients' and employees' mail. (Check with local postal authorities in establishing mail security) ____
3. Policy covering information to the press, friends and relatives regarding condition of patients ____
4. Telephone and telegraph calls: Incoming and outgoing (official, patients', personnel) ____
5. Soliciting or canvassing within the hospital by individuals or organizations ____
6. Personnel employment and policies (see section on personnel) ____

Admission, discharge and death

7. Responsibility of the admitting office ____
8. Reservation of accommodations ____
9. Waiting lists ____
10. Admitting office routine on admission ____
11. Business office routine on admission ____
12. Admission to the nursing unit ____
13. Transfer of patients ____
14. Discharge of patients ____
15. Nonprofessional routine to be followed in disposition of bodies ____
16. Administrative and professional routine in autopsy cases ____

Professional staff

17. Application of medical standing orders ____
18. Orders for treatment ____
19. Consultation before major operations ____
20. Authorized abbreviations for technical terms ____

Resident medical staff

21. Composition of the resident staff ____
22. Private practice away from hospital ____
23. Quarters and meals ____
24. Uniforms and laundry ____
25. Smoking while on duty ____
26. Relationship to nursing staff ____
27. Duty hours ____
28. Duties and responsibilities ____
29. Contributions to medical literature, i.e., approval required, etc. (Also applies to nursing staff) ____

Surgical department

30. Scheduling of operations ____
31. Time of admission of surgical patients ____
32. Preoperative routines ____
33. Operating room technique ____
34. Safety precautions in use of explosive anesthetics ____
35. Detail of preparation technique for common operations ____
36. Routine treatment of postoperative conditions ____

Emergency department

37. Immediate care of the patient ____
38. Dressings (changes, routine, etc.) ____
39. Paying patients (referral to private physicians, collection of fees, etc.) ____
40. Free patients (assignment to physician, etc.) ____
41. Reports (accidents, medico-legal cases, medical reports, etc.) ____
42. Dog bites (notice to health department, etc.) ____
43. Tetanus prophylaxis routine ____

Obstetrical department

44. Floor routine on admission ____
45. When labor begins ____
46. In the pre-delivery room ____
47. In the delivery room ____
48. Equipment provided (routine and special) ____
49. Post-partum care (persons authorized to provide, etc.) ____
50. Routine in cases of abortion ____

Pediatric department (newborn)

51. Routine care following birth ____
52. Bathing routine ____
53. Nursing hours for infants ____
54. General routine in the nursery (including "showing" of infants) ____
55. Isolation nursery procedures and isolation policies ____
56. Ritual circumcision ____
57. Routine treatments ____
58. Premature babies ____
59. Standing formulas and technique for preparation ____

Pediatric department (children)

60. Admission procedure and restrictions (age limits, etc.) ____
61. Discharge procedures ____

62. Routine administration _____
63. Laboratory examinations (including oral bacteriological) _____

Radiology

64. Requisitions for service (form and information required, submission routine, etc.) _____
65. Sending patient to department _____
66. Preparation of the patient for various types of examinations _____
67. Routine for various examinations and method for reporting results _____

Laboratory service

68. Routine laboratory work to be performed _____
69. Collection of specimens (methods, times, personnel authorized, etc.) _____
70. Delivery of specimens to laboratory _____
71. Submission of reports _____

Pharmacy

72. Prescription orders (forms, submission, charges, etc.) _____
73. Stock drugs and solutions (by floors and departments, etc.) _____

Nursing service

74. Floor supervisor (duties and responsibilities) _____
75. General floor rules (for all nurses) _____
76. Uniforms required _____
77. Seriously ill patients (reports required, etc.) _____
78. Floor dressing rooms (restricted use of, etc.) _____
79. Arrangement of the medical record _____
80. Communicable disease (reports required, isolation routine, etc.) _____
81. Special nurses (qualifications, responsibilities, payment) _____
82. Routine of supplies _____

Dietary department

83. Responsibility of dietitian _____
84. Meals to physicians and visitors _____
85. Meal hours (patients and employees) _____
86. Time to order diets (special, new, etc.) _____
87. Floor dietary service (extent provided, person responsible, etc.) _____
88. Routine diets (by types) _____

Medical records

89. Duties of department _____
90. Preservation of medical records _____
91. Statistics cards (composition and disposition, etc.) _____
92. Checking medical records by librarian _____
93. Medical records committee of the medical staff _____
94. Indexes required (by disease, operation, physician, etc.) _____
95. Reports (monthly, yearly, etc.) _____
96. Assistance in research (by librarian to medical staff) _____
97. Responsibility for producing the record _____
98. Confidential information (release of, etc.) _____
99. Transcripts of the medical record (authority required, etc.) _____

Accounting and business office

100. Room fees (schedules) _____
101. Delivery of statements of accounts _____
102. Collections (responsibility and methods) _____
103. Special charges (methods, time due at office, etc.) _____
104. Willful damage to property _____

Purchase and supply

105. Duties of the department _____
106. Authority of the department _____
107. Authority to make special purchases _____
108. Purchases from storeroom _____
109. Parcels and packages carried in and out of the hospital by employees _____

Mechanical and maintenance

110. Duties of the department _____
111. Requisitions for repairs _____
112. Emergency repairs _____
113. Persons authorized to make electrical connections _____
114. Routine, scheduled inspections _____

Housekeeping

115. Responsibility of the housekeeper _____
116. Assignment of maids and porters _____
117. Cleaning material (issued and charged to housekeeper, etc.) _____
118. Linen circulation (controlled issue, etc.) _____
119. Responsibility for linen room _____
120. Damaged linen (immediate return to linen room via laundry) _____
121. Replacement of worn linen _____

Laundry

122. Nonresident employees _____
123. Resident employees _____
124. Personal laundry _____
125. Charge for damage _____

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A tuberculosis hospital for mental patients

GEORGE W. JACKSON, M.D.

THE ARCHITECTS of the pleasant looking hospital shown on these pages might well think of themselves as wizards of the jigsaw puzzle, as well as masters of their profession. The puzzle they have put together is the design for a structure with an unusual number of special requirements.

Fundamentally, the building is a 112-bed psychiatric-tubercular unit of the Arkansas State Mental Hospital System, in Little Rock. Thus the first requirement is a design suited to the care of psychotic patients who also are suffering from active tuberculosis.

Second, the unit is the first of a whole group of new buildings to be constructed for the state hospital. As such it must set the stage for those to follow. All of the old buildings now standing are to be razed and facilities are planned for 1,500 patients on the present grounds.

The third major requirement is that the building have adequate facilities for a medical teaching center, since it also is to be utilized by a proposed new school of medicine for the University of Arkansas. This building and those to follow will be used for the training of medical students and nurses attached to the university, as well as state hospital personnel.

Considering all of the details that these three characteristics impose, it is not difficult to appreciate the careful planning necessary for such a structure.

Foremost among the functions of this new unit will be the medical and surgical treatment of patients suffering from active tuberculosis. Screening of patients and initial mental and tuberculosis diagnoses will be made in the adjacent hospital plant. Also, as soon as treatment in this unit renders patients noninfectious, they will be transferred to other buildings for treatment of their mental illness.

Dr. Jackson is superintendent of State Hospital, Little Rock, Ark.

ARCHITECTURAL SOLUTION

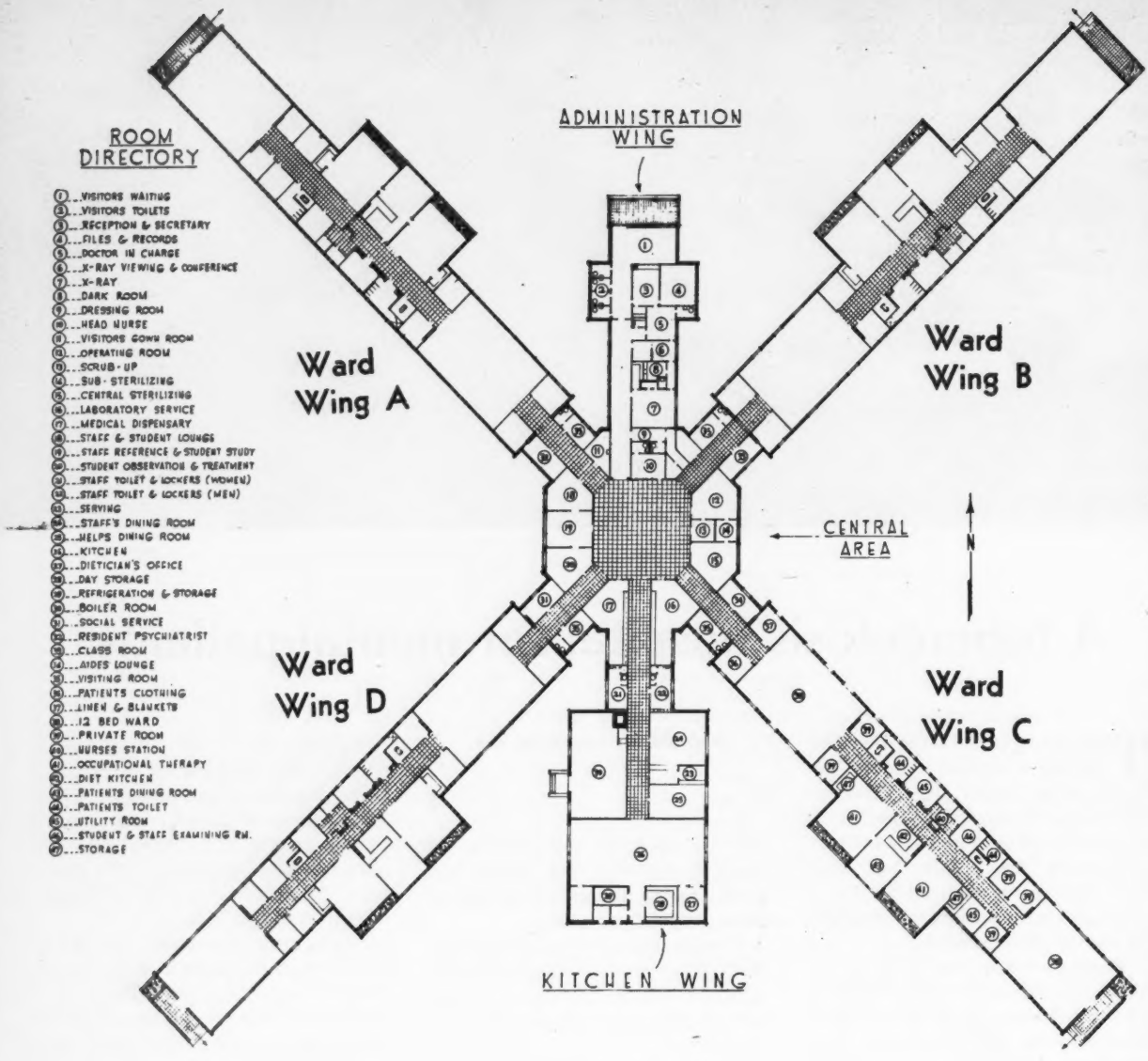
An extended single-story plan, cruciform in shape, with six wings joined by a central area, was decided upon as the most satisfactory solution to the many problems involved. Total cost was set at $778,460, of which $86,115 is required for equipment.

The floor plan of the hospital resulted from the need for satisfying three major requirements: (1) Segregation of patients into compatible groups, (2) centralized supervision and control, and (3) distinct separation of the various activities of the hospital.

Segregation of patients: The excitable nature of mental patients usually requires a finer degree of separation than is necessary in general hospitals. In this hospital the following separations were deemed necessary: (1) Violent and suicidal patients from depressed or cooperative patients, (2) male patients from female patients, (3) bedfast patients from ambulatory patients, and (4) colored patients from white patients.

By breaking up the total bed complement into eight major units of 12 beds each, more than enough opportunities are offered for comparative isolation of the different groups. Additional segregation is offered by the use of two-bed cubicles (separated by sneeze screens) in the wards.

Centralized supervision and control: For each of the four major wings, the use of a single nursing station flanked by two 12-bed wards provides centralized control



plus the necessary segregation. It also provides efficient supervision with a minimum of personnel.

This station projects out into the corridor so that the nurse on duty has a maximum view of the entire area. From her vantage point she can observe the two wards, the occupational and recreational therapy room, the diet kitchen, the utility rooms and the examining section. (See wing floor plan.) This also places the nurse where she is easily seen by the patients, an important factor in care of the mentally ill.

The head nurse's station, at the confluence of the four wings, is situated for control of all traffic to and from the ward units and to and from the technical services.

Traffic in and out of the hospital, whether consisting of staff, patients or visitors, is readily controlled by the administrative office.

The dietitian, from her position, can control all service traffic to the kitchen wing, and can oversee entry and departure of all service help.

Separation of activities: Each ward unit provides for all of its patients the required facilities for bedrest, nursing care, occupational therapy, and serving of meals. Separation of the two wards, where it is desired, is facilitated by a sliding door in the corridor adjacent to the nursing station. Two more sliding doors are located at either end of the wing's central area. They can be closed to separate the wards from the private rooms, utility rooms, and treatment departments. This is an advantage where it is necessary to enforce rest periods for ward patients, or where it is desirable to isolate them from the central area.

The nurse's station is planned to afford maximum protection against infection for the nurse on duty. Ordinarily she makes her exit to the patient's areas through the examining room, where sterile gowns and masks are kept. She returns to the station through this same room,

after a stop at a scrub station and removal of the contaminated mask and gown. In case of an emergency, the nurse can make direct exit to the ward areas.

Separation of x-ray, fluoroscopic, surgical and laboratory facilities has been effected by placing them in the hub of the building or directly accessible to it.

The administrative unit and the kitchen and service units are well removed from the medical and nursing facilities.

Teaching facilities are provided by the student and staff examining room in each wing, by the student observation and treatment room in the central area, and by a classroom in the same location.

STRUCTURAL FEATURES

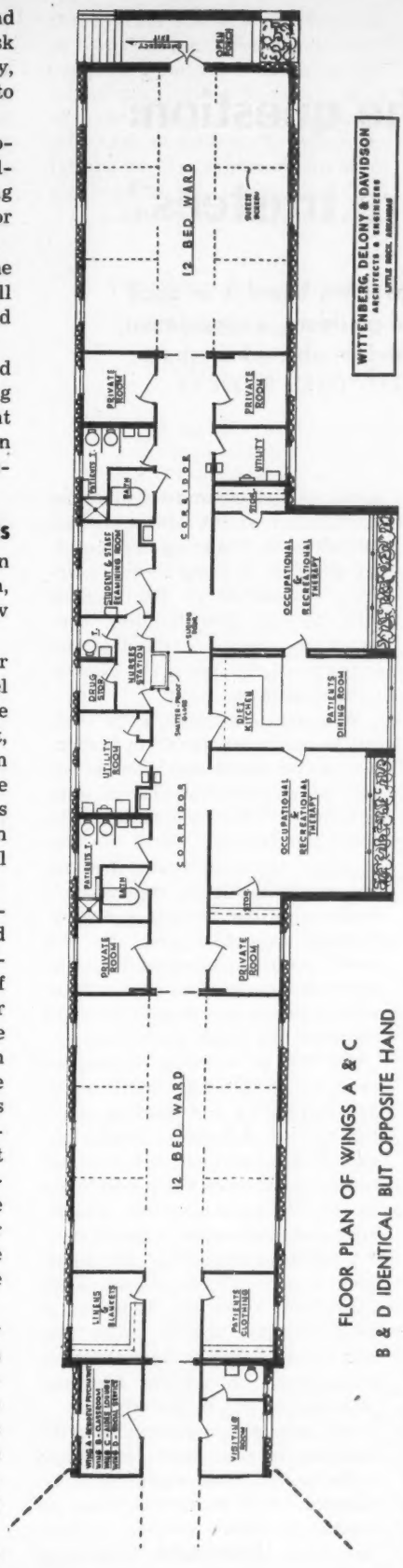
Reinforced concrete has been used for footings and foundation, and for the framework of the new hospital.

All areas within the exterior walls are spanned clear with steel joists. This permits: (1) Complete flexibility of interior arrangement, since there is no interference from structural members, and (2) future extension of the plan or changes in the existing plan at minimum cost and without risk of structural damage.

Materials and finishes were chosen for low maintenance costs and for ease of cleaning. On the interior, floor and wall finishes are of terrazo or ceramic tile wherever water conditions or abnormal usage require constant cleaning or a high resistance to wear. Asphalt tile floors and enameled plaster walls are used where less abuse is expected and where more resilient and decorative finishes are desirable. Acoustical plaster ceilings are used in all areas where traffic or patient congregation might cause unusual confusion or an excessive amount of noise.

The major portion of the exterior is brickwork. Between the windows are job-fabricated aluminum panels, which were placed to give pleasing yet inexpensive relief to the low extended masses of the building. These panels are rustproof and have good insulating properties.

All windows in the nursing units are of the louvre type. They allow maximum ventilation and yet are easy to clean. Protective screens inserted inside the windows provide additional security by preventing the escape of patients or injuries due to broken glass.



FLOOR PLAN OF WINGS A & C

B & D IDENTICAL BUT OPPOSITE HAND

Heating, electrical and dietary facilities were designed to provide the maximum in patient health and well-being, and at the same time to avoid the hazards of patient self-injury or the risk of infection.

Heat is provided by a radiant panel system that consists of a series of copper coils embedded in the plaster ceiling. This provides a warmth that is draftless and evenly distributed—thus ideally suited to hospital requirements. Problems of contagion are minimized since there is no mechanical interchange of air between any of the areas. Elimination of radiators guards against patient self-injury.

Fixtures for electrical facilities in patient areas are all recessed as a further protection for the irrational patient.

For quick exchange of information between the ward nurses and the head nurse, an intercommunicating call system has been installed. This is particularly desirable where there are likely to be disturbances in the wards.

TELEVISION INSTALLATION

A special feature of the electrical system is an installation of television conduits. Television sets are to be installed in the occupational therapy areas of each ward and are to be under monitoring control of the head nurse. It is expected that carefully selected television programs will be of distinct therapeutic value by helping to revive in patients the normal interests and contacts of the outside world.

Kitchen and serving facilities have been carefully separated from patient areas to minimize contamination risks. Food is prepared in the central hospital kitchen and delivered in electrically heated carts to personnel serving kitchens and the wards. Each ward unit contains its own facilities for washing and storing eating utensils used by its patients. Ambulatory patients are fed in the wing dining rooms, one ward at a time. Bed patients are served by attendants.

To answer the question: How good are trustees?

A hospital governing board is as good as an informed president, a cooperative membership and an able administrator.

LEONARD W. HAMBLIN

IT SEEMS TO ME THAT trustees are no better than the president of the board or the administrator. Even with the very best of material on the board, unless the president has the necessary "spark" and the administrator is well suited for his job, the board will not function well. The president is the key man, and all administrators should work to the end that the right man is guided into this spot. Also, the board must be ruled by a very effective constitution and by-laws.

The nominating committee must select capable men and women, who should be picked for their influence in the community, as well as for their church affiliation, character, ability and profession. We have 15 such members on our board, which consists of the following: Two married women, one doctor (no voting power), one contractor, one Y.M.C.A. director, two sales executives, one banker, two retired businessmen, one vice president of a business and four presidents of businesses. We hope to bring to the meeting of this board leaders of the small outlying towns, who will give us the pulse of their locality, although not voting.

We have quite a few standing committees that are active. Any nonstanding committees, after serving their usefulness, are disbanded and new ones appointed when the necessity arises. Our list of committees at present is: Executive, personnel, finance, building and grounds — maintenance and construction, purchasing, public relations, special committee to revise constitution and by-laws, special committee in financing new building program, nursing school, executive committee of the medical staff, special new building construction, special committee for endowment plan and a fire prevention committee.

With one exception, each committee has as its chairman a member of the board and consists not only of trustees but also of individuals in the community who have had training along the line in which the committee functions. For example, our fire committee is made up of one trustee, a fire insurance executive and the fire chief, with the president of the board as a member ex officio. Thus, we are grooming prospective board members on these committees.

We try to schedule committee meetings so that they do not average more than one meeting every two months. A meeting usually begins with a luncheon and does not last more than one and a half hours in all. We have excellent attendance and accomplish a great deal. For instance, one of our new members, a very influential man in the community who has been on at least 30 other boards, stated that our board meetings were the most stimulating, interesting and best attended of any in the city.

All information pertaining to the meeting is gone over beforehand with the chairman and the administrator, and in many cases an agenda is mailed to each member for study beforehand. Sometimes action is taken by telephone calls, but in all cases we cover these proceedings in our monthly meeting so that a record is made in the minutes. Because some of our monthly board meetings have been too long, we are considering a limit of two or three main topics.

The tentative business schedule has worked out well as follows:

1. Approval of minutes of previous board of trustees meeting.
2. Executive committee — president.
3. Financial report—chairman.
4. Personnel committee — chairman.
5. Building and grounds committee—chairman.
6. Medical staff—chairman.
7. Purchasing committee—chairman.
8. Public relations and nursing school committee—chairman.
9. Special committees.
10. Administrator's report.

Any items pertaining to these committees are listed under the committee with details, which are coded at the bottom of the page. After the above listing, an information and suggestions list is made, keeping the board informed as to articles in current periodicals.

Many administrators feel that their boards should not be informed of problems within the institution—for example, a breakdown in the refrigerator plant, medical shuffle, serious personnel problems, or perhaps a purchase of considerable expense. How are trustees expected to retain their interest unless they are told that these things are going on rather than having to learn of them through the proverbial "grapevine" or pick them out from the monthly report? Board members must have responsibility if they are to be good members.

Probably the best way to keep board members informed is for the administrator to present his particular problem to the committee concerned before the matter is brought up at the general board meeting. He will get a different slant and a clearer picture of the situation himself if he is able to present the details fully to a small group particularly fitted to discuss and offer advice on the situation. In addition to the trustees, nearly every committee consists of tech-

Mr. Hamblin is administrator of Deaconess Hospital, Freeport, Ill.

nically trained members from the community.

This procedure will not only give committee members a feeling of responsibility but will also assist the president in more efficiently handling the business at the monthly board meeting. A matter that comes up for discussion with a committee recommendation is much more apt to be disposed of expediently. At the present time I am a member of two boards and three committees. Of these I feel that only two are worth-while, because in the others the president or chairman has not done enough preliminary work on the agenda. As a result, the meetings are too long and often break up with little or nothing having been accomplished.

A fine example of the help and cooperation that the administrator may expect from board members is presented in an article in *Reader's Digest*, "How to Get Nurses Galore." In this story a doctor explained to a new board member how difficult it is to recruit student nurses. This board member could not understand why it could not be done. He set about to prove that it could be done and did a wonderful job. This does not mean that the "magic wand" can work all the time, but it does prove that suggestions and thinking outside of the hospital can bring new thinking that stimulates ideas.

Before an administrator can change his policy and take board members into his confidence, he has to be sure that this confidence will not be abused. The danger that help from board members might make them assume too much responsibility in solving hospital problems, thus usurping the power of the administrator, may be avoided if the administrator has the right understanding with the president and the board.

We have heard occasional statements to the effect that our board is one of self-perpetuation because at the expiration of a term a member is never voted out by the rest of the board. Generally speaking this is true, but because of death and business obligations we average from one to two changes each year on our board. Those who criticize our procedure should bear in mind that it takes more than just three years for a board member to learn the many complications of running a hospital. So in reality board members with many years of experience are very valuable ones to us in making decisions pertaining to the general welfare of the hospital and community.

It is better that board meetings should not always run smoothly, for a controversial problem thrown in now and then tends to keep the board on its toes. These discussions should be controlled by the president, however, before getting too heated—the president is not only the dynamo but also the brake of a well-functioning board.

SOME QUESTIONS TO ASK

When moving to a new hospital

BEFORE MOVING from one hospital to another, an administrator made up a check list, for his guidance, of questions he wanted to ask his predecessor about details of the hospital operation. He had only one day in which to ask the questions. A year has gone by since the move, and the administrator reports that experience has proved these questions comprehensive and valuable. They are reproduced here in full.

1. Is an organization chart available?
2. Is there an established job analysis with evaluations and salary schedules?
3. Is there a list of the medical staff and officers? Is there a constitution of the medical staff?
4. What is the schedule of regular meetings of trustees and medical staff or other established groups?
5. What personnel policies are written?
6. How is the insurance handled? Where are the insurance policies kept?
7. Where is the charter or corporation papers of the hospital?
8. Are there any special contracts to which the hospital is a party?
9. What relations or contracts are made between the hospital and radiologist, pathologist, anesthesiologist, or other medical specialist?
10. How is the intern and resident program organized and supervised?
11. What bank accounts are there and what signatures are necessary for checks?
12. When is pay day for employees?
13. What are the supplementary sources of income other than patient payments?
14. What relations are there with Blue Cross?
15. How are alcohol and narcotics controlled?
16. Is there a ladies' auxiliary?
17. What kind of relations are there with the newspapers?
18. What relations are there with the police?
19. Where is the nearest fire house? Is there an organized fire crew or fire drill plans?
20. What responsibility for emergency care does the receiving ward have?
21. Are there particular responsibilities in relations with the city, county, state, or federal governments?
22. Is there a local hospital council or association of hospital administrators?
23. What keys does the administrator have?
24. How is the hospital operated at night?
25. How is the hospital operated on weekends?
26. What daily and weekly schedule of work has the administrator customarily had?
27. Is there a union representing any group of employees?
28. Are there any "sacred cows" among trustees, staff, or hospital personnel?

EDITORIALS

Administration checklist

TO ANYONE IN THE profession it is scarcely news that a hospital is a complicated mechanism, but few if any persons have realized to what extent this is true. Even veteran administrators, therefore, are expected to be surprised when they dip into "Elements of Hospital Operation," a special presentation to be found in this issue of HOSPITALS.

For the first time an effort has been made to count and classify the scattered details encountered in opening a new hospital, and the inventory shows far more than a thousand.

Here is one of the many good by-products of the Hill-Burton program. The Public Health Service is properly interested in seeing that federally aided hospitals are ready to give adequate service from the start. Since many of these are built in communities where there has been no previous experience with hospital operation, the need for such literature is great. This factual report by the Public Health Service will help to improve the quality of all hospital care.

In compiling and revising the material, it was necessary to call upon several administrators for comment. The replies left no doubt that such information will be almost as useful in long established hospitals as in new ones. Many commentators found it a penetrating checklist of basic administrative procedures — and some confessed deficiencies in their own operations.

If hospital administration is complicated, it is also subject to controversy. Not all administrators will agree with all suggestions and with the distribution of emphasis, but this is to be expected. The report is nevertheless an extremely valuable guide, and it is published as recommended reading.

A further opportunity

SOMETHING HAS HAPPENED to the composure of those who would sell socialized medicine and socialized hospital service under the attractive label of "national health insurance." Gone is their self assurance and their patient explanations that national health insurance is no more socialized than public school education, or the postal service, or federal reserve banking.

The new approach is characterized by sarcasm and ridicule. The country is found to be infested with reactionaries who are "against health, against social security, against education, against a living wage, against everything that means anything to ordinary people; and in the end against our very liberty, our opportunity, our hopes for the future."

This is quoted from a recent speech by Federal Security Administrator Oscar R. Ewing. Such reactionaries make up a "League of Frightened Men," Mr. Ewing explained. He went on:

"Here we have to do with the American Medical Association chapter of the League of Frightened Men. It is a very active chapter and extremely well heeled. Its members—however outstanding they may be as physicians—are not only fat-cats but fraidy-cats.

"And what are they afraid of? Of all things, they are afraid of improving the health of the American people. They are afraid of having enough doctors to take care of the American people. . . . Above all, they are afraid of any system that would make it possible for people to pay for the medical and hospital care they may need throughout their lives."

Because doctors do not embrace socialized medicine, they are fat-cats who oppose health, education and a living wage! This has the earmarks of desperation. It is unlikely to impress members of Congress, and it may be looked upon as a further opportunity to build an adequate health program that does not destroy voluntary effort.

(Presstime note: See the news section, this issue, for Mr. Ewing's more recent statement that he is "not wedded to national health insurance" if someone has a better solution. See page 37 for a long list of alternatives that is growing fast.)

Consumer representation

FROM TIME TO TIME a request is made for more consumer representation on the board of a voluntary health organization. This usually comes from someone associated with labor unions, and frequently the voluntary health organization involved is Blue Cross.

Any such proposal has a quick appeal. We like to think that every person in this country has something to say about what happens to him. Millions of people are consumers of hospital service through Blue Cross, and so why shouldn't they have a spokesman on every Blue Cross board?

Of course these millions of consumers have no organization of their own, but a large number of them do belong to labor unions. Since organized labor has a plentiful supply of articulate leaders, why not formally recognize them as the spokesman for consumers of hospital service?

One answer to this question may be found in a paper read at the Midwest Hospital Association Convention this year on behalf of Harry Becker

of the UAW-CIO. An excerpt from that paper:

"We believe it is especially important that Blue Cross avoid using the subscribers' money for propaganda against national health insurance. Labor regards this as an improper expenditure . . . . There is great need for increased and effective public representation on the boards of Blue Cross plans. Our local unions feel very strongly on this subject."

The above quotation should be judged with certain facts in mind. Mr. Becker's organization was one of the first, if not the first, to press for Blue Cross coverage as part of union-management contracts. In his Kansas City paper, moreover, the author was offering *friendly* criticism.

Although it was made in good faith, Mr. Becker's statement cuts quickly to the heart of the question of consumer representation on the boards of voluntary health organizations. What the statement says in effect is this: "Our local unions wish to represent the public (consumers) but our first purpose will be to fight for the adoption of union philosophy and union policy."

Such an approach is understandable in view of organized labor's history. Most gains have been won by hard and often bitter fighting, by fanning class hatred, by organized resistance and mass pressure, by demanding much and yielding little, by resorting to violence if necessary to avoid compromise.

It is a serious mistake, however, to assume that the same approach could benefit hospital patients. The only successful boards of voluntary health agencies are those *not* torn by bickering and the clash of pressure groups. The secret lies in a submerging of all personal and group interests in a single cause of better service to the sick.

Organized labor has something to contribute to better hospital service, and it has done so in a number of communities. Wherever such an experiment has worked, however, labor's representative has recognized the nature of his assignment. At board meetings he has been able to leave behind the battle strategy and special purposes of trade unionism and to think about hospital service exactly as the corporation president sitting next to him thinks about hospital service. He has been content to represent the public as the public, or consumers as consumers, and that is all it takes.

Healthy black ink

GREAT BRITAIN'S voluntary hospital system died a sudden death two years ago this month, it is said, mainly because the individual hospitals were financially too weak to survive on their own.

The hospitals were hit hard by World War II, of course, but the primary reason for their weakened condition was of earlier origin. That is, they never developed as facilities widely used by the paying patient. Their charity load was too heavy. They were too much entangled in government regulations long before World War II. They were financially weak because, by tradition and custom, they were financially unsound.

Against this background, the table below should be of interest to administrators of voluntary hospitals in the United States. The figures presented here, taken from last month's Statistics and Directory issue of HOSPITALS, cover only the classification of general and special short-term nonprofit hospitals in this country, and they are patient-day figures.

	1946	1947	1948	1949
1. Total income exceeds total expenditures	$ .44	$ .27	$ .06	$ .52
2. Total income exceeds patient income	$1.72	$1.35	$1.77	$2.08

Line 1 shows that these hospitals, which symbolize the voluntary system, have operated consistently in black figures since the close of World War II. Even though the 1949 net surplus is modest enough, it represents a new postwar high in financial soundness.

Line 2 shows that over a period of three years the paying patient himself has not kept pace with the hospital's income requirements. This dollar-and-cents trend is substantiated by a percentage calculation: Hospitals depended on other sources for 13.2 per cent of their income in 1949, for 12.5 per cent in 1948, and for only 11.2 per cent in 1947. (In the very bad year of 1946, it was 16.4 per cent).

This may be a reasonable generalization. Statistically the voluntary hospital system in America is financially sound at the moment. Because of this, the rising figure for income from sources other than payment by patients is not significant. The significant fact is that total income more than equals total expenditures; that voluntary hospitals in this country continue to find a sufficient amount of other revenue.

While there is no cause for alarm, the situation is worth attention. The 52-cent net surplus is a national average, and not all hospitals can show it on their books. In fact, the 1949 averages for three regions show a net operating deficit.

There is more to good administration, of course, than an easily balanced budget. Almost any hospital can balance the budget by ignoring its primary obligation of adequate community service.

With this in mind it would be a worthwhile exercise for every administrator to make use of these figures from the Statistics and Directory issue of HOSPITALS, to see where his or her hospital stands with respect to "par" for the region and the nation.

Federal health legislation

(Continued from page 40)

ing a sudden upheaval or revolutionizing the present system.

CATASTROPHE INSURANCE

H.R. 6766. *Sponsored by Representative Bosone.* Mrs. Reva Bosone, a former municipal judge in Salt Lake City, has introduced a compulsory health insurance bill in which benefits would be payable on a "$50 deductible" basis. That is, when a participating citizen has paid $50 in medical care (including hospital care) or $25 for dental care, the Federal Security Administrator "shall pay the balance of the charges for services so furnished." Subject to regulations of the Federal Security Agency, the program in each state would be administered by a state board of health of 15 members appointed by the state medical society. Interference with administration of any participating hospital and selection or compensation of personnel would be specifically forbidden. Mrs. Bosone would finance her bill by a 3 per cent payroll tax on earnings up to $3,600 per year with an additional 1 per cent from general tax funds just as in S. 1679.

This deductible feature has intrigued many thinkers in the country who have been seeking a way to avoid excessive use of benefits that threatened to bog down the British system. Senator Douglas of Illinois is said to be working on a legislative proposal of his own which would embody this principle. It is attractive to those who believe that assistance would be provided only in catastrophic cases. It does carry the same dangers of control and has all of the difficulties inherent in a government-regulated system of distributing health services. If it be said that the government would audit only those bills which are in excess of $50, it should be remembered that the first $50 would likewise be subject to some supervision in order to prevent abuses. Like the sliding scale of subscription charges under the Flanders-Ives bill, this "deductible" feature is superficially attractive.

INCOME TAX ADJUSTMENTS

H.R. 7418. *Sponsored by Representative Boggs.* Present federal income tax law permits deduction of medical expense in excess of 5 per cent of gross income to determine taxable income. Representative Boggs would modify this. If a taxpayer had a gross income under $2,000, Mr. Boggs would let him deduct all of his medical expenses. For an income between $2,000 and $4,000, the deduction would be the excess over 1 per cent of gross income. From $4,000 to $6,000 it would be 2 per cent, and from $6,000 to $8,000 it would be 3 per cent. From $8,000 to $10,000, the deduction would be the excess over 4 per cent of gross income, and over $10,000 it would be 5 per cent.

H.R. 6819. *Sponsored by Representative Keating.* This bill treats income tax and medical expense in a radically different way. If gross income were under $2,000, the Keating bill would permit 90 per cent of health insurance subscription charges to be deducted from the tax itself. For income between $2,000 and $4,000, 85 per cent of the health insurance subscription charges might be deducted from the tax. For income between $4,000 and $6,000 the deduction would be 80 per cent. From $6,000 to $8,000 it would be 75 per cent and from $8,000 to $10,000 it would be 70 per cent. For incomes over $10,000 the deduction would be 60 per cent of health insurance premiums.

This would put the federal government in the position of paying a large portion of the health bills of the nation and, of course, only approved health insurance subscription charges would be qualified, thus leading to some measure of federal control. Naturally the income tax would have to be increased to allow for this additional expenditure. But the device set forth in the Keating bill has had the support of some Catholic leaders and is advocated in a statement of the Catholic Hospital Association.

A criticism of both the Boggs and Keating bills is that many of our citizens who most need relief on medical expense do not file income tax returns.

These, then, are the major health proposals facing the present Congress. Some of these plans have a familiar ring to those who sat in previous Congresses. Others are recent or new, and this is encouraging for it indicates that our legislators are not growing stagnant in their thinking.

A gradual change has been taking place in the national health legislation picture. This change seems to reflect a growing optimism—a reaffirmation of faith in the voluntary system.

A MATTER OF CHOICE

It is no longer "compulsory health or nothing." Rather it is a choice of several methods and a groping for workable schemes. Why must we do anything? Simply because to stand still is to stagnate, and progress is part of the American psychology. There is a tremendous urge on the part of the public for a workable method of insuring against the financial hazards of catastrophic illness. One insures a house against fire; why not a human being against ill health? Because while a house has a fixed value there is no limit to the possible cost of health care. How can we promise unlimited care except with an unlimited budget?

The American Hospital Association may take justifiable pride in its forward looking program of hospital construction in areas of greatest need, development of voluntary health insurance on a nationwide basis, and government responsibility for the indigent. It supports the Hill bill as a means of carrying out the last point.

You make the comparison

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	a. Easily read upside down or right side up	✓	
	b. Reduces possibility of error	✓	
	c. Saves time in solution identification	✓	
4	**POP-UP BAIL**		
	a. Automatically pops-up when bottle is lifted	✓	
	b. Holds Saftiflask securely—safely—in ice-tong grip	✓	
	c. Design of bail saves storage space	✓	
5	**VACUUM SEALED**		
	a. Mechanically induced vacuum protects all solutions (Blood Bottles, too) in Saftiflasks	✓	
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	a. Full line of standard and special-purpose U. S. P. solutions	✓	
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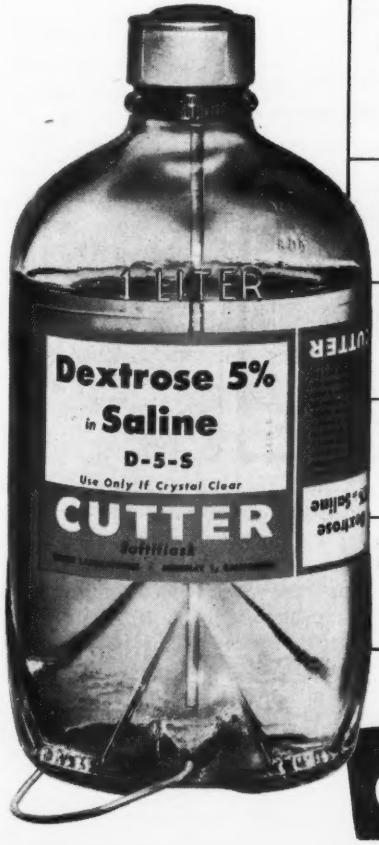
	a. Smaller, stronger, lighter carton saves storage space	✓	
	b. Carton label easy-to-read, identify	✓	



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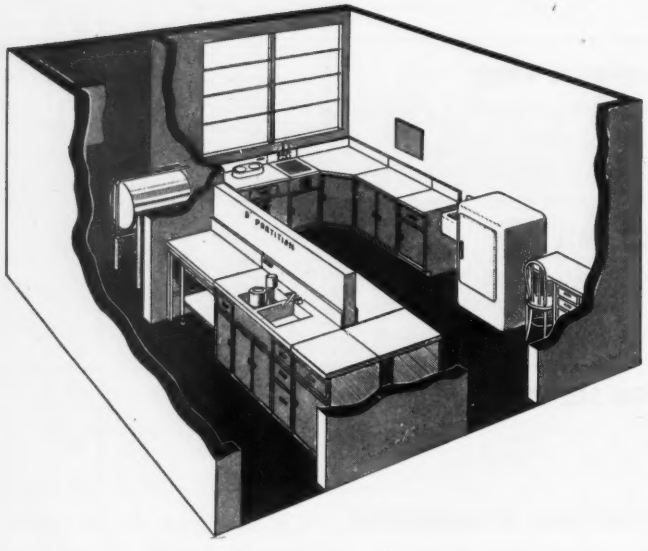

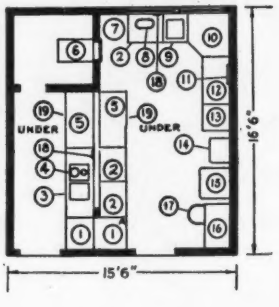

MILK FORMULA ROOM FOR A GENERAL HOSPITAL

EQUIPMENT LEGEND

GROUP 1 (FIXED)

1. 85L-24D—Drawer-Cupboard Unit without Splashback
1a. 85-L-24DSS—Drawer Cupboard Unit with Special-Depth Top
2. 85L-D35—Table Top Units with 85X-27 Legs (3 Prs. Required)
3. 85L-72AS—Double Sink Unit
5. 85C-47—Counter Top Units with 85X-27 Legs (2 Prs. Required)
6. 85L2238M—Milk Formula Sterilizer
9. 85L-24AS—Sink Unit with Stainless Steel Grill
10. 85L-39—Corner Unit
11. Bulletin Board
12. 85L-35—Cupboard Unit
13. 85L-24D—Drawer-Cupboard Unit
14. Lavatory
18. 85ES-2—Electrical Duplex Plug Strip

GROUP 2 (NOT FIXED)

4. Olson Bottle Washer
7. 85P6398AL—Waste Receptacle-Silver lustre Finish
8. 85P5363—Double Element Hot Plate
15. Refrigerator
16. 85P6238—Nurses' Desk—Silver lustre Finish
17. 85P6327AL—Chair—Silver lustre Finish
19. 85P6356—Milk Cart

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Careful buying is essential for good public relations

EDGERTON HART

AT BEST, human beings become hospital patients with considerable apprehension. Strange, mysterious, and, to be sure, miraculous things happen to them while under its roof. Generally, however, it is the doctor whom the patient credits, while often, after discharge, he gives but little credit to the hospital. In such instances, there has been a failure in handling human relations.

To avoid sending out dissatisfied patients, the hospital must examine some of the elements of its relationships with the people who are dependent on it. We are concerned here with some public relations aspects of purchasing—the role that can be played by the hospital purchasing agent in selecting equipment and supplies which can make a direct contribution to that all-important program of increasing public esteem. The case history of a hypothetical patient shows how dissatisfaction begins.

The patient, first entering the hospital, goes from a pleasant, sunny out-of-doors into a corridor dimly illuminated with antiquated, or new but just plain poor, lights. He is laboriously assisted into a rickety wheel chair and is rolled along on squeaking wheels. Janitors, laundry helpers, cooks and other employees go about their duties in sick-looking, ill-fitting uniforms of assorted styles and colors.

At the elevator there are sounds of bumping and rattling chains from the well as the car starts and stops en route down; then, tugging and squeaking, the door opens and in goes the patient. We can imagine his feelings, as he sits in an antiquated wheel chair suffering from his malady, when the worn-out clutches on the elevator motor suddenly take hold and with a violent jerk the car starts its unsteady ascent. Up they go with additional jolts, jerks and squeaks as the elevator operator attempts to line up the car with the third floor. Down another corridor the patient notices the same depressing lack of proper lighting fixtures. And so to bed, where shortly he has a sedative, becomes drowsy and sleeps.

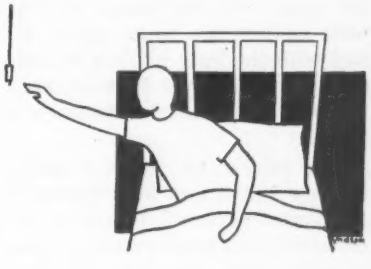
The next morning in comes a wheel stretcher for the trip to the operating room. Moving from bed to stretcher is nerve racking because the wheels have no braking mechanism and the stretcher will not stay put. Aboard at last away they go, with all wheels vibrating, for another distracting ride on the elevator.

INFERIOR LINEN

As he enters his period of convalescence, the patient begins to sit up and take notice. His cheap inferior sheets, too narrow and too short (which were purchased supposedly as a "real bargain"), have pulled out all around, and since he can move but slightly he lies in discomfort on folds and ridges. The paint on the walls, also a supposed bargain, is not only off color but peeling. He turns his head for a glimpse of the sunny out-of-doors, and the faulty window glass distorts his view and dizzies his head.

Later the attendant enters, clothed in her drooping, ill-fitting uniform, and with her comes the first food the patient has had in 24 hours. The bouillon, main dish and tea are merely tepid, the nurse's explanation being that there is no way to keep the food hot when it comes up from the kitchen. The pork chop is tough, the tea like dishwater and the gelatin dessert tasteless. Presented with such unpalatable food, the patient nibbles but half of everything and then snoozes until mid-evening to awake hungry. Here is a food buyer who never stopped to think of the important part that good quality food, well prepared and properly served, can play in developing favorable human relations.

Day after day the patient is raised up in his bed with squeaks, vibrations and little jolts caused by cheap construction in his bed, bought more for the shape and looks of the end boards than for the quality of springs and mattress. Every morning the radiator in his room rattles and cracks because of poor valve construction, and it emits odors because of the wrong kind of paint. Shoe soles squeaking up and down the corridors on the wrong kind of floor wax disturb him. Too often there is a nerve-grating grinding and groaning outside his room as the "bargain" floor polishing machine does its ineffectual job.



In this manner the hypothetical patient convalesces under the roof of some hospital, an experience about which many of his friends and associates will quiz him upon his return to a normal way of life. Before forgetting this dissatisfied patient, however, let us mention other equipment that might have affected his life in the hospital.

Practically every patient should have a bell cord easily accessible to him, one with a button that

Mr. Hart is executive director of the Hospital Industries' Association, Chicago. This article is adapted from an address he presented at the Mid-West Hospital Association convention, Kansas City, Mo., April 1950.

works with very little finger pressure. More important, at the other end of the cord there should be a call indicator that works infallibly. The bedside table, upon which the patient depends for so many little conveniences and small pleasures, should not only be pleasant to see but should be of ample size and proper design. The appearance, stability and size of the apparatus on which the patient's food tray is placed should be seriously considered by the purchasing agent.

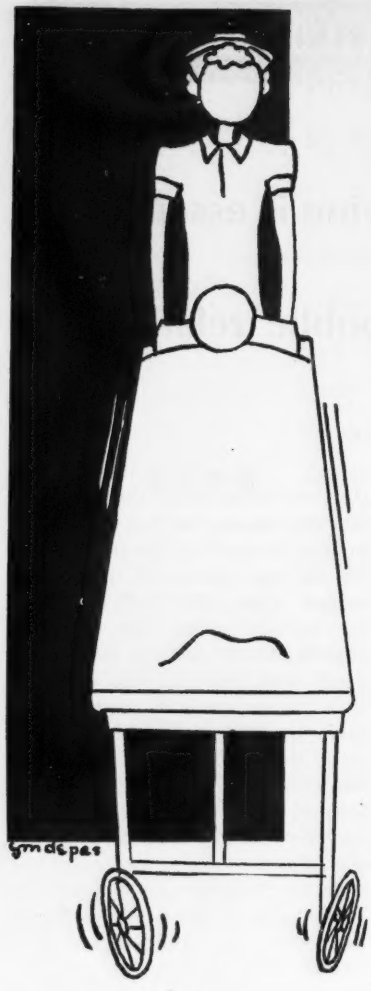
In connection with meals, there is an item which might be considered of very minor importance —the napkin. When one is completely idle in a hospital, he depends upon little things for a sense of well being. The difference in quality between a good paper napkin and a poor paper napkin can play an important part in the general satisfaction the patient derives from a meal.

Another inconvenience to patients is the frequent lack of paper handkerchiefs. At a cost of less than one cent per day, patients can be provided with this little item, which contributes much to comfort and can be very important.

Inadequate or poor lighting fixtures are particularly disturbing. A central lighting fixture may be suspended from the ceiling with a large white globe dangling from the end. Patients, arranged around the ward with the heads of their beds against the walls, spend all day with the light glaring in their eyes. Nothing could be more conducive to eye strain, headaches and fatigue.

The subject of wards suggests another instance of total disregard for human relations. Offensive odors often are a problem when many patients are roomed together. There are many deodorants which will control this problem very easily and excellent equipment to dispense them. Then, too, in wards it is of the utmost importance that there be a sufficient number of easy working and properly designed movable screens. On those many occasions when patients desire considerable privacy, there must be no delay or confusion in arranging for them to have this basic courtesy.

Visitors are another segment of a hospital's public. Although visitors



can be an irksome problem for the hospital personnel, they play an important part in the recovery of patients. These visitors come and go and they comment to friends in the community about their visit. Certainly the first point in such comments is the condition of the patient. The next point is an appraisal of the institution.

It is important to have in rooms and wards satisfactory facilities for visitors. This does not mean having overstuffed easy chairs or divans throughout the hospital, but adequate and comfortable seats should be available even if space allows nothing more than the new and splendid folding chairs. Here again the purchasing agent must exercise care and devote thought to the construction of the chairs because, as with all things, there are uncomfortable, rickety, cheap ones on the market, which in some instances might be considered worse than none. During the long vigils which often take place at the bedside of critically ill patients, the close relatives certainly would welcome decent reading lights near their chairs to help pass the anxious hours.

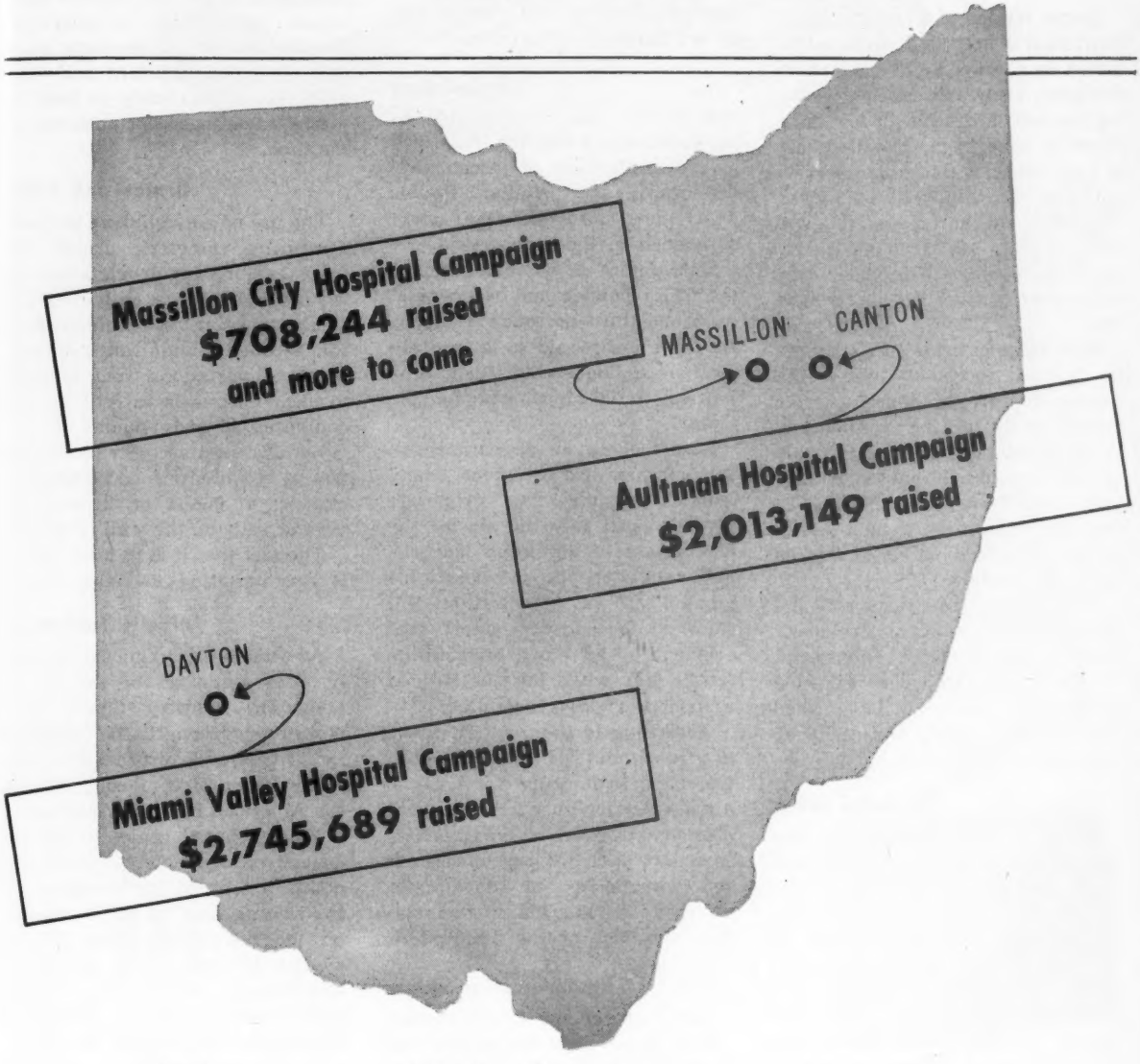
From personal experience, I can testify that on the occasion of my own nervous hours in the waiting room on the maternity floor of a large hospital, awaiting arrival of my first youngster, there seemed to be a total lack of planning for the comfort of the fathers. There were too few chairs, inadequate ash trays, poor lamps and, even worse, nothing but obsolete torn magazines and booklets, and no place within a hundred yards to get a drink of cold water. When I paid the bill, I had the feeling that there was much to be improved in the general atmosphere of that hospital.

In selecting the many items of equipment and supplies which they require, purchasing agents should always have in mind the functions that they expect the items to perform. The human relations function should be added to the usual list of functions. Food can do more than merely nourish a patient. Elevators should not only carry people from floor to floor, but they should do so without startling the riders. A bed is something more than a contrivance to keep a patient in a convenient place for doctors and nurses, and in addition it should be a comfortable place in which the patient can recover. Bed lamps must not be of the type that emits a general glow from a fixed position on the head of the bed; they should be flexible and of a style and power assuring that patients will have sufficient footcandles of light on the reading material to avoid eye strain.

In short, the purchasing agent makes a direct contribution to the good public relations of his institution when he is guided by the reaction of the public in making purchasing decisions.

The Purchasing department is edited by Leonard P. Goudy, purchasing specialist.

Three Ohio hospitals raise almost $5½ million!



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PURCHASING COMMENT

Straight-locking caster

ZIGZAG motion of wheeled equipment used in hospitals can be eliminated by a new type of caster now available. Only two straight locking casters are needed for each piece of equipment, installed one at each end. As the attendant begins pushing, the lead caster locks instantly and automatically. The other casters are free to swivel while the locking caster keeps the equipment rolling in a straight line.

Side aisles or cross corridors can be turned accurately since the equipment pivots under perfect control on the leading locking caster. A slight push against the side of the equipment automatically and instantly releases the lock so that the equipment then is easily moved sideways on its four free swiveling casters.

Self-locking casters may be installed on such units as stretchers, food trucks, portable equipment, trucks and linen carts. Wheeled equipment thus can be pushed more quickly, safely and easily by only one person.

Threaded shank

Another development in the caster field is the threaded shank. It is contended that a sturdier caster can be made — that the shank does not become loose in the post of the bed and that the casters cannot drop out when the bed is being moved on or off elevators or over obstructions. The threaded shank is screwed into a nut which has been welded into the bed.

This type of caster has been used for more than a year by New York City hospitals and has been given a trial by the Armed Services Procurement Bureau. It has now been adopted as standard for federal procurement by the Federal Specifications Board.

Since many hospitals have beds on which patients cannot be placed in shock position without raising the foot of the bed, it is expected that an extension to the shank will be developed for this purpose.

Aerosol fogs

A device now is available to produce aerosol fogs for the widespread application of insecticides, deodorants and similar liquids which are most effective when suspended in the atmosphere.

This device is portable, weighs only 11.5 pounds and is powered by a one-third horsepower motor. Its operation is said to be entirely mechanical, depending upon centrifugal force developed by the motor.

Also making an appearance on the market are a great many gadgets designed to evaporate glycol vapors into the air for the destruction of air-borne bacteria. Reference to the Association's manual on air sterilization will show studies to the effect that ethylene glycol has a high killing power only when the humidity of a room is rigidly controlled.

According to the manual, glycol vapors without such humidity control have little value for hospital air sterilization purposes. This conclusion, however, is not intended to reflect upon the use of aerosols for insecticides or deodorants, which do not depend on the relative humidity of the atmosphere.

Standardization values

Several recent developments would have been impossible had hospital bed sizes not been standardized and a number of bed heights formerly in use been eliminated. The type of wheel stretcher which allows easy transfer of the patient to bed cannot accommodate beds that vary greatly from the standard 27" height.

If this type of equipment proves to be an advance and is adopted to any considerable extent, users of it can thank the committee which, years ago under the chairmanship of John Hatfield, was responsible for the elimination of many varying heights of beds.

Along with the bed, hospital mattress sizes were standardized. Users of the new contour sheets would have most likely found them to be considerably more expensive if it had not been possible to limit production to the few sizes of mattresses being used in hospitals. Elimination of unnecessary sizes and types of equipment and supplies seems invariably to lead to future advantages not apparent at the time.

Drains and tubes

The use of polyethylene in manufacturing catheters, drains and tubes is a recent development. It is a synthetic plastic with electrical insulating properties, remains flexible through a wide range of temperature variations, and is inert to such chemicals as will be encountered in body fluids.

Because of its construction, the flow is less likely to be reduced by clotting of blood or deposits of organic salts on the wall of tubing.

The fact that it is so inert makes it less irritating to living tissue.

Plastic tableware

At a meeting in Chicago recently, representatives of the plastic tableware industry finally gave tentative approval to the simplified list of tableware sizes recommended by the purchasing committee of the American Hospital Association.

While printed copies of the list are not yet available, hospitals may obtain a copy of the tentative list by writing and asking to be put on the list of acceptors. Letters should be addressed to W. E. Braithwaite, Commodity Standards Division, National Bureau of Standards, Washington 25, D.C.

At the same meeting, approval was given to a commercial standard for plastic tableware. A hallmark has been adopted and will be used by tableware manufacturers who mold tableware according to the standard.

Hospitals are advised to limit their purchases of plastic tableware to those products bearing the hallmark.—L.P.G.

Further information about materials referred to in these columns may be had by writing to: HOSPITALS, Editorial Department, 18 E. Division Street, Chicago 10.

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Current price trends

A GENERAL UPWARD movement of prices on almost all fronts dominated the wholesale commodity price picture during the month of May. By the beginning of June the price index for all wholesale commodities had risen to 156 1 per cent of the 1926 statistical "normal." This was an increase of 1.6 per cent above the index of the previous month.

The Bureau of Labor Statistics reported that from the end of April until the beginning of June spot primary market prices for a total of 28 products had increased by more than 4 per cent.

Economists now are predicting that 1950 will be a bigger business year than 1949 and that good times probably will extend well into 1951. Although prices are rising, there seems to be no general fear of real inflation. Output is high and getting higher. Steel, automobile, and construction industries are all operating at record levels. Stockpiles of goods to be sold are still relatively large.

Prices for crude rubber have led the parade of increases with a jump of more than 20 per cent since the end of March 1950. At the beginning of June, crude rubber was selling at 29 cents a pound, the highest it has been at any time since 1928.

In markets for meat animals the general downward trend of the first few months of 1950 was sharply reversed. Prices for hogs increased from $17.05 per hundredweight at the beginning of May to more than $20 at the end of the month. Steer prices rose sharply at the beginning of the month to $29.25 per hundredweight and then remained firm through the first week in June.

Mixed price movements on the grain markets produced a net effect of "no change" during the month.

Wholesale food prices followed the general trend upward, with major increases concentrated in prices for meats. Further increases are predicted but probably will be checked by the relative abundance of foodstuffs. There were a few cuts in food prices, the most notable being another reduction in the price of coffee. In the middle of May a new 1950 low for this product was set when the price dropped to 46 cents a pound.

On textile markets there were increases for both wool and cotton products. The price of wool on Australian markets has risen to an all-time high, even exceeding prices during the postwar boom of 1920. In this country, prices for wool tops exceeded $1.95 per pound for the first time since July 1948, and some manufacturers have raised blanket prices 10 to 15 cents apiece. The six-month slide of cotton fabric prices was sharply reversed late in May under pressure of large scale market activity. Still more price increases have been predicted.

In the building industry, price rises have been spurred by tremendous activity. Construction is proceeding at the record rate of 21.8 billion dollars a year. The price of lumber, which already was 299.4 per cent of the 1926 "normal" at the beginning of May, rose sharply during the month. Prices for metals and metal products also were up. Copper rose a full cent to the highest level in more than a year. Prices of steel scrap in the Chicago market advanced $2 a ton to reach a new high since mid-March of 1949.

TABLE 1—UPWARD MOVEMENTS

Weekly Index Numbers of Wholesale Prices—1926=100

COMMODITY	May 24 1949	May 31 1949	April 25 1950	May 2 1950	May 9 1950	May 16 1950	May 23 1950	% of Change 5-24-49 to 5-23-50	% of Change 1-3-50 to 5-23-50
All commodities	156.0	156.1	153.7	154.5	155.1	155.9	156.1	+0.1	+3.7
Farm products	172.8	173.7	160.2	162.7	162.9	164.7	165.3	—4.3	+7.4
All foods	165.1	165.9	157.4	158.8	158.7	160.5	160.7	—2.7	+4.0
Textile products	139.4	135.5	135.3	135.4	135.3	135.4	135.6	—2.7	—1.4
Fuel and lighting materials	130.1	130.5	131.1	132.1	132.2	132.6	132.8	+2.1	+2.1
Metals and metal products	167.8	167.3	170.3	169.6	170.1	170.3	171.0	+1.9	+0.9
Building materials	193.4	192.2	194.3	194.5	197.0	198.0	198.5	+2.6	+4.3

This weekly wholesale price index is designed as a weekly counterpart of the monthly wholesale price index. It is based on a sample of about one-eighth of the commodities in the comprehensive sample and therefore should be regarded as an indicator of price trends rather than as a final compilation. The monthly index should be used for fuller coverage.

Source: Bureau of Labor Statistics.

TABLE 2—SLIGHT DOLLAR DECLINE

Monthly Index Numbers of Wholesale Prices 1926=100

COMMODITY	April 1940	April 1942	April 1944	April 1946	April 1948	April 1949	March 1950	April 1950
All commodities	78.6	98.7	103.9	110.2	162.8	156.9	152.7	152.9
Farm products	69.4	104.5	123.2	135.4	186.7	170.5	159.4	159.3
Foods	71.6	98.7	104.9	110.8	176.7	162.9	155.5	155.3
Textile products	72.9	97.7	97.8	107.9	150.3	142.2	137.3	136.4
Cotton goods	70.2	113.8	113.9	137.6	219.2	176.2	176.5	172.9
Fuel and lighting materials	71.8	77.7	83.0	86.1	131.6	132.0	131.5	131.3
Anthracite coal	77.4	83.7	95.8	104.0	124.6	135.0	141.9	142.6
Bituminous coal	96.4	108.2	120.3	125.2	178.9	190.7	198.5	193.5
Electricity	76.0	64.4	59.9	66.6	66.1	67.9	*	*
Gas	82.0	78.1	77.1	79.7	89.1	92.3	88.3	*
Building materials	92.5	110.2	115.2	126.5	195.0	196.5	194.2	194.8
Brick and tile	90.2	98.0	100.3	119.9	152.5	160.8	163.3	163.4
Cement	90.3	94.1	93.9	102.4	127.5	134.3	134.9	134.9
Lumber	96.7	131.8	154.1	171.4	309.2	290.6	295.9	299.4
Paint and paint materials	86.7	100.6	104.4	108.0	158.6	157.9	138.2	136.7
Plumbing and heating materials	80.9	98.5	91.8	100.8	138.7	154.9	151.9	154.8
Structural Steel	107.3	107.3	107.3	120.1	155.8	178.8	191.6	191.6
Other building materials	92.3	103.8	102.8	112.8	162.2	173.8	172.2	172.0
Drugs and pharmaceutical materials	81.8	115.5	112.0	112.4	153.8	123.0	121.9	122.0
Raw materials	73.0	100.0	113.2	122.2	175.5	165.8	162.8	162.5
Semi-manufactured articles	78.2	92.8	93.6	101.1	154.1	153.1	144.1	143.9
Manufactured products	81.2	98.7	100.8	105.5	157.6	153.0	148.9	149.4
Purchasing power of the dollar	$1.272	$1.013	$ .962	$ .907	$ .614	$ .650	$ .655	$ .654

**Figures not available at press time.*

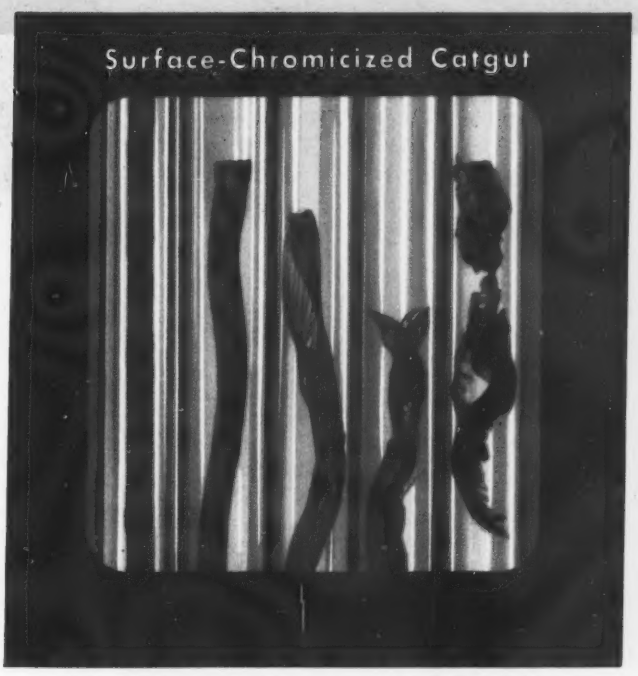
Source: Bureau of Labor Statistics.

Surprising Differences Revealed in Catgut Digestion . . .

THE MATERIAL: Surface-chromicized after spinning and drying. The chrome concentration is very high in the surface layers and relatively low in the core of the strand.

THE RESULT: In enzyme solution, the core of most surface-chromicized catgut digests readily, leaving a hollow cylinder which separates into ribbons.

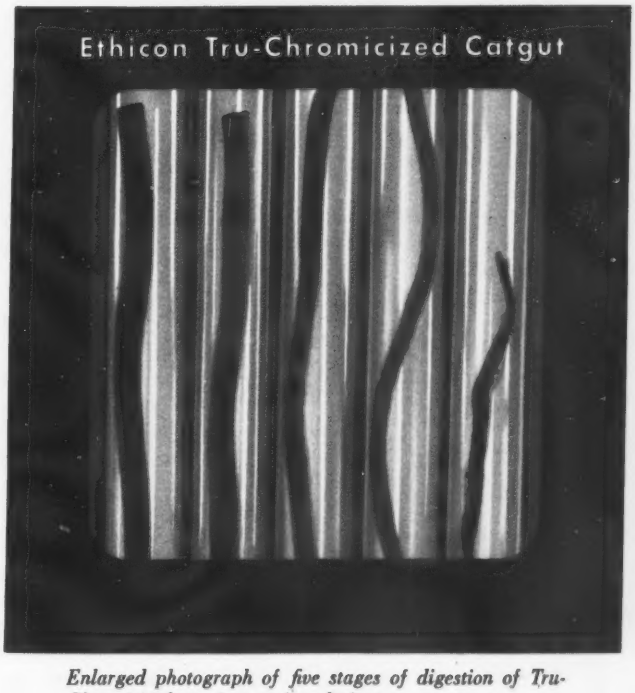
This cylinder may be excessively resistant to enzyme action and persist in tissue, frequently leading to knot extrusion.



Enlarged photograph of five stages of digestion of surface-chromicized gut in trypsin solution.

THE MATERIAL: By the Tru-Chromicizing method, individual ribbons of catgut are soaked in chrome bath *before* they are spun into strand, permitting uniform deposition and full control of chrome concentration.

THE RESULT: The Tru-Chromicized strand has the same chrome content from periphery to center, and hence exhibits uniform enzyme resistance throughout digestion. Ethicon's Tru-Chromicized gut digests on the surface and retains its integrity as a unified suture until digestion approaches completion. Total digestion eliminates knot extrusions.



Enlarged photograph of five stages of digestion of Tru-Chromicized gut in trypsin solution.

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Bio-Sorb Powder displaces the always potentially dangerous talc.

Seamless Atraloc Needles, with the smooth shank, possess uniform high temper, without soft areas. Parallel flattened surfaces permit firm grasp by needle holder. All points are hand-honed.

If you are not familiar with the many advantages of Bio-Sorb and Atraloc, your local representative can supply full information.

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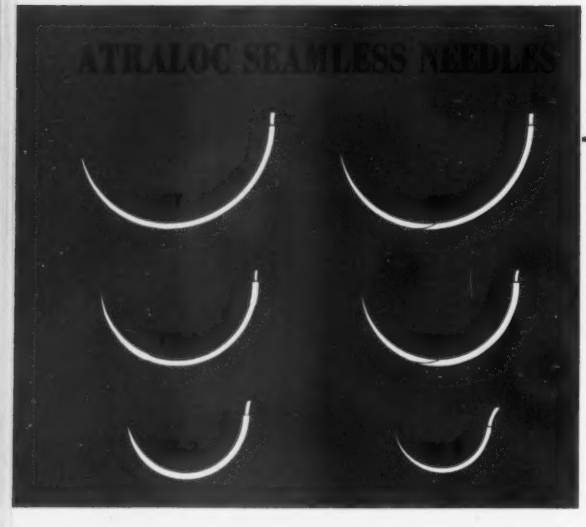

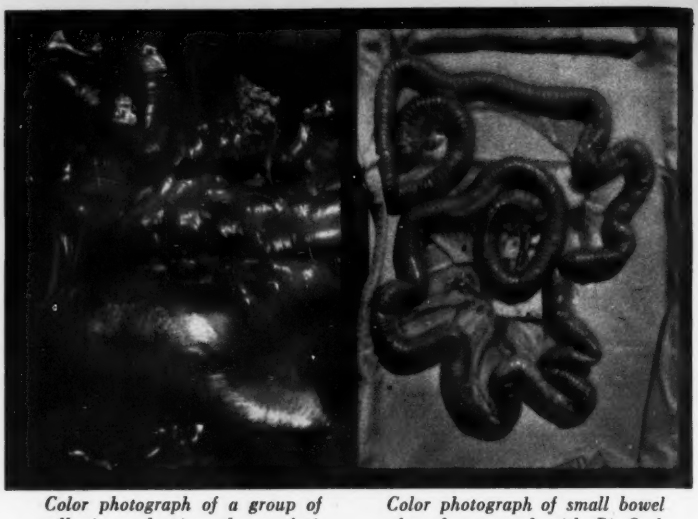

Color photograph of a group of adhesions showing the agglutinated talc masses appearing as white flecks within the adhesions.

Color photograph of small bowel of a dog treated with Bio-Sorb Powder. Note complete absence of adhesions or demonstrable inflammatory reaction.

Glove Powder Adhesions Eliminated With New Bio-Sorb Starch Powder.

Postoperative adhesions caused by glove powder have long been a serious concern of surgeons and operating room assistants. All published studies agree that talc as a glove lubricant is unsafe.

As a replacement for talc, a wholly safe and efficient dusting powder is now available. This new powder, called Bio-Sorb, is a mixture of amylose and amylopectin, derived from corn starch, which has been treated by special physical and chemical means to prevent gelatinization when the product is autoclaved. It is treated physically and chemically to assure good lubrication after sterilization.

Talc consists chiefly of magnesium silicate. It causes granulomatous reactions in tissue, resulting in intra-abdominal adhesions, persistent sinus formation, or nodules in the wound.

Implantation of glove powder may occur from unwashed gloves, perforations in gloves, spill on to sponges, instruments and suture material, and by the air-borne route.

Bio-Sorb is compatible with body tissues and is rapidly absorbed. It does not injure rubber gloves. It fits regular O. R. technics. Costs less than 2 cents per operation. Bio-Sorb has been used over three years in several hundred hospitals. Complete literature mailed on request.

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After extensive research in surgeon's preferences, Ethicon designed the 6 needles shown at left, which meet the requirements for 80% of the needles used in abdominal closure.

These needles are swaged to Ethicon's Tru-Gauged, Tru-Chromicized Surgical Gut, noted for its strength and flexibility.

ETHICON SUTURE LABORATORIES

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Suture Laboratories at New Brunswick, N. J.; Chicago, Ill.; Sao Paulo, Brazil; Sydney, Australia. In Scotland: Mersons (Sutures) Ltd., Edinburgh.

Preventive maintenance begins on the architect's blueprint

C. W. SIGNOR

PREVENTIVE MAINTENANCE may be described as a systematic program designed to forestall wastes of labor, materials and fuel and to prevent failure of equipment before the expiration of its maximum useful life.

To many people, preventive maintenance begins when a building is first occupied—actually it should start long before. For any building, whether hospital, office, or industrial, there are three important phases relative to preventive maintenance:

(1) When the building is being planned on the drawing board.

(2) During construction of the building and installation of equipment.

(3) After the building has been completed and throughout its useful life.

Too often, the engineer who will maintain the building is not consulted or even employed until the last of these three phases. In some cases where he may be present, little weight is attached to his opinion. The architect and designing engineer may be skilled in layout and the contractor may be skilled in actual construction, but usually it is the maintenance engineer who appreciates the numerous small details that go into the easily maintained plant and equipment.

A discussion of the first two phases will demonstrate how they can affect preventive maintenance in the third or operating phase.

When building plans progress to the point where locations of various items of steam-using equipment are known, the layout of the steam piping and return piping is made. Steam piping must be laid out so that it is in the correct balance for all equipment to heat evenly. Piping must be of a size to deliver the required amount of steam without undue pressure drop. The return piping must have sufficient condensate-carrying and air-eliminating capacity to insure proper operation of all equipment that uses steam.

Any piping subjected to temperatures in excess of ordinary room temperature will expand. If the piping is restricted during this expansion, forces will be set up which can develop annoying leaks in joints and fittings. Sometimes these forces can break the piping. The designing engineer should use offsets, expansion joints, and hangers in his piping layout so that the piping is not under stress when heated.

UNDERGROUND PIPING

Within the building, underground steam and return piping should be avoided if at all possible. Such piping is much more subject to corrosion than similar piping installed above the floor, and it is more costly by far to repair or replace. Underground piping often will develop leaks which waste both heat and condensate. This waste may go on for many months without detection. In many buildings, underground piping may be found which has been abandoned and replaced with new piping above the floor.

Although, generally speaking, underground piping is not desirable, there are a few instances where it may be practical. When a return main must pass a doorway, in order not to interfere with the opening, the return can be run below floor level in front of the door. It is important to provide an air loop above the door and to maintain the proper grade in the piping on both sides.

Also, when it is necessary to supply steam to buildings that are separated from the power plant building, underground steam and return piping may be used. In such installations, protection from the soil, protection from mechanical injury, underdrainage and insulation are very important.

In buildings where steam is supplied to different classes of equipment—laundries, kitchens, sterilizers, water heaters, and building heating systems—it is good practice to have separate steam supply and return piping for each class of equipment. This will prevent surging of condensate, water hammer, back-feeding of steam from one system to another through the return, and slow venting of air from the steam-using equipment. Elimination of the above will result in economy of operation and reduced maintenance.

The heating systems in a larger building should be designed so that each exposure of the building will be a separate heating zone. With automatic controls on these zones, the tendency of the wind and sun to cause uneven heating can be overcome. The benefits of a controlled zone system are manifested by increased comfort and savings in fuel and labor.

The size of steam valves to be used for throttling service, such as pressure reducing valves and temperature regulating valves, is important. If these valves are unduly oversized, they will operate with little clearance between the valve and seat. This will increase the effect of a condition known as "wire drawing," which consists essentially of erosion of the metal by steam. The life of an oversized valve is thus shortened, and maintenance on the valve is increased. Single-seated valves are more easily repaired than double-seated

Mr. Signor is supervisor of customer steam service, the Detroit Edison Company, Detroit. Adapted from a paper presented at the American Hospital Association's Institute for Hospital Engineers, St. Louis, May 1950.

valves when they are wire drawn. Some single-seated valves are constructed with special alloys that are highly resistant to erosion by steam.

STEAM TRAPS

The steam trap is an important part of any equipment that requires steam. It functions to relieve the air and condensate so that the steam-using equipment, steam mains, and risers will operate as they were intended. Improper operation of the trap will cause trouble with equipment and a waste of fuel.

There are many types and sizes of steam traps from which to choose, and careful selection should be made. They should be able to withstand the required steam pressure, keep the equipment free of condensate, vent the equipment, and keep steam from entering the return piping. The working parts, such as valve and seat, air vents, floats, and linkage, should be of sturdy design and should be replaceable.

Various metals and alloys are used to make the working parts of steam traps, such as brass, bronze, monel metal, chrome steel, stainless steel and others. The common metals, such as brass and bronze, are used for low-pressure traps, while chrome steel and stainless steel are used for the more severe service needed in high-pressure traps. Monel metal is a satisfactory metal for low and medium pressures.

Traps for any building should be of standardized sizes and types, to keep the stock of spare parts at a minimum. The ease with which parts are obtained from the supply house or the manufacturer should be considered in the selection of traps.

Oversized traps should be used on the ends of steam mains to take care of the abnormal flow of condensate when steam is turned on.

The trap selected for service on an instantaneous water heater should be very rugged, since this is about the most severe type of service to which a trap can be subjected.

When steam is supplied by underground mains to one or more buildings, there is a possibility of the outside of steam mains becoming flooded with water, causing an increase in the steam condensing rate. The traps bleeding these mains should have sufficient capacity to drain condensate if the mains become flooded. Undersized traps can cause water hammer which, if severe enough, will break fittings and allow steam and condensate to escape. This might result in personal injury or property damage.

For equipment such as multiple-roll ironers, steam presses and multiple-coil driers, each steam-using element should be separately trapped. This will insure proper venting, condensate draining, and an even heating of equipment.

The Engineering and Maintenance department is edited by Roy Hudenburg, secretary of the Council on Hospital Planning and Plant Operation.

WATER HEATING

A fundamental of water heating is that when temperature is kept below 140° F., corrosion is usually minor. When water is heated above this temperature, corrosion increases correspondingly.

Water heating corrosion develops into two types of maintenance problems. The first is corrosion of piping until leaks develop. The second is plugging or partial plugging of branch lines and runouts due to deposits of corroded material.

In the original layout of a building where hot water will be required for kitchens and laundries at 170° F. or above and domestic hot water at 120° to 130° F., the designing engineer should, as a rule, use separate water heaters and water systems to keep maintenance due to corrosion at a minimum. Systems laid out in this manner also will produce savings in fuel.

CONSTRUCTION PHASE

During the erection of a building, considerable supervision is necessary from both the architect and the designing engineer to insure that plans and specifications are being followed by the contractor.

It also is important at this time that someone inspect the installation of equipment to see that it can be maintained with a minimum of effort.

Such parts as traps, valves, vents, and expansion joints should be kept in the open where they can be repaired. Where appearance calls for concealment of these items in walls, partitions or false ceilings, sufficient room should be left around each item for repair or replacement and access panels should be provided.

There should be an adequate number of unions and valves, and these also should be conveniently placed.

Equipment to be maintained should be sufficiently removed from hot surfaces or piping to avoid burning the hands and arms of maintenance men.

Where the equipment to be serviced is heavy—water heater elements, vacuum pumps, and heavier steam traps—steel beams should be installed above the equipment so that chain hoists or other mechanical aids may be used when working on them. This will reduce the chances of physical injury to maintenance men.

Also, since working from step-ladders or scaffolds is dangerous, equipment should be placed so that it may be maintained from the floor wherever possible.

OPERATING PHASE

When a building is completed and first occupied, the steam-using equipment usually is in the best operating condition. Each item is efficient and little steam is wasted. But if maintenance is neglected, this efficiency is decreased until eventually an additional 20 per cent or more fuel is needed to operate the building, and steam-using equipment becomes increasingly unreliable.

In some buildings maintenance is allowed to lapse until failure of equipment forces maintenance work. At such times, it usually is more than the building engineer can cope with, and outside help is necessary. Maintenance then becomes very costly.

The most efficient way of handling the maintenance problem is to set up a preventive maintenance

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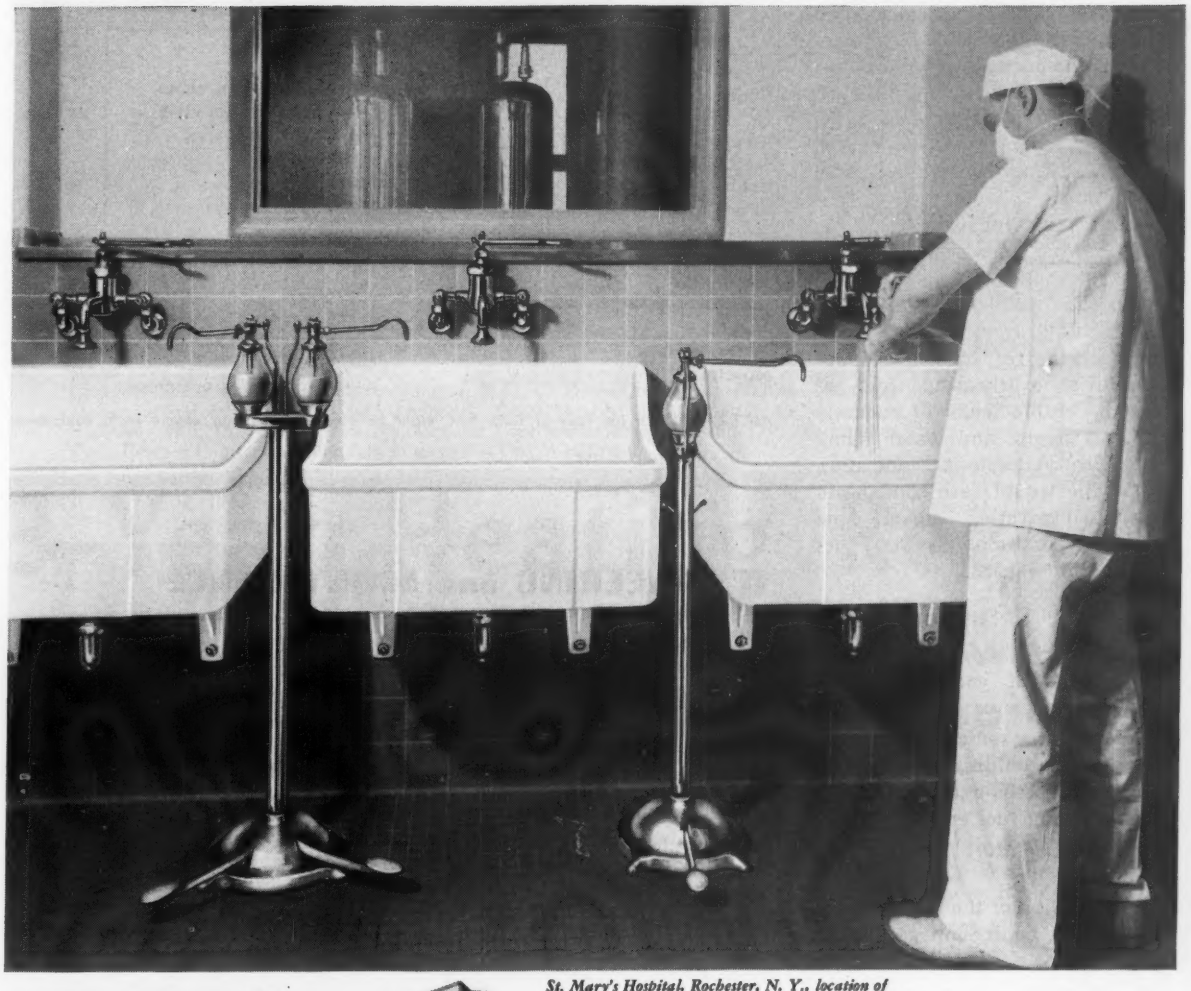
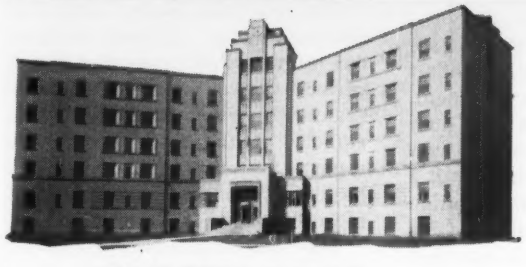


St. Mary's Hospital, Rochester, N. Y., location of the Duraclay Scrub-up Sinks pictured above.



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program. Various items to be maintained should be classified and arranged into groups so that work can be done on a production basis. In hospitals, particularly, the equipment which is critical to efficient operation should be given frequent inspection. The accompanying illustration is a sample of the types of forms that may be used. Any engineer can make a complete listing for the building he maintains.

With a maintenance program in operation, the engineer still should be alert to signs of needed maintenance. The usual signs, which are not difficult to recognize, are sluggish operation of equipment, underheating, overheating, loss of vacuum, visible leaks of condensate and steam, and water hammer. Also valuable as indicators of possible trouble are condensate meters, integrating steam flow meters, water meters, and fuel consumption records.

LIST OF BENEFITS

A summary listing of the potential benefits of good preventive maintenance are as follows:

1. Maximum efficiency in the operation of building heating systems and process equipment, with accompanying fuel economy.

2. More comfort in building heating.

3. Extension of the useful life of steam-using equipment and accessories.

4. Reduction of the possibilities of personal injury or damage to the building and electrical equipment from steam leaks.

5. Provision of a full year's constructive work for men generally not considered usable during the summer months.

6. Acquisition of better mechanics through the exclusive use of fulltime employees. Such men will have more interest in their jobs.

7. Reduction to a minimum of maintenance work requiring overtime or outside assistance.

8. Establishment of preventive maintenance as a stable item on the budget.

9. Peace of mind for the engineer and the administrator.

ENGINE ROOM EQUIPMENT

NAME OF BUILDING ..... RECOMMENDED INTERVAL BETWEEN INSPECTIONS..... 1 YEAR

DATE OF INSPECTION..... RECOMMENDED TIME FOR INSPECTION

Vacuum pumps	No. 1	No. 2
STRAINER		
PACKING FOR PUMP SHAFT		
CHECK IMPELLER CLEARANCE A		
LUBRICATE MOTOR A		
LUBRICATE PUMP A		
VACUUM SWITCH		
FLOAT		
CHECK VALVES		
AIR SEPARATOR		
GATE VALVES		
STARTING BOX		

Water heaters	No. 1	No. 2
COILS		
GASKETS		
TEMPERATURE CONTROL VALVE		
PACKING FOR CONTROL VALVE		
PACKING FOR GATE VALVES		
WATER HEATER TRAP		
BLEEDER TRAP		
TEMPERATURE OF WATER	180°F.	135°F.

Symbols

√—REPLACED
X—FOUND IN GOOD WORKING ORDER
O—PLACED IN GOOD WORKING ORDER
C—CLEANED
A—AS SPECIFIED BY MANUFACTURER

INSPECTED BY.....

AN EXAMPLE of the type of form that might be used in inspecting engine room equipment.

ENGINEERING and MAINTENANCE COMMENT

Creating high humidity

THERE IS apparently revived interest in the provision of high-humidity rooms for the treatment of respiratory diseases.

The preparations made at one hospital in waterproofing a room for such use therefore may be of interest to others. The waterproofing was provided by refacing the walls and ceiling with a hard cement plaster, covered with a high-grade enamel. The floor was prepared with a number of thicknesses of roofing paper and was asphalt topped with waterproof cement. To dispose of condensate, a floor drain was installed. The door was prepared with the installation of a vapor seal. While the information provided makes no mention of installation of a double window, that would seem to be advisable in order to prevent extremely severe fogging.

Humidity was provided by two portable humidifiers, each about the size of a table-model television set. These units required a water supply, drain and ordinary lighting current outlet. One of the machines was sufficient to bring humidity up to saturation in 30 minutes. The second machine was used for extra-fast saturation of the atmosphere in case of emergency and as a spare.

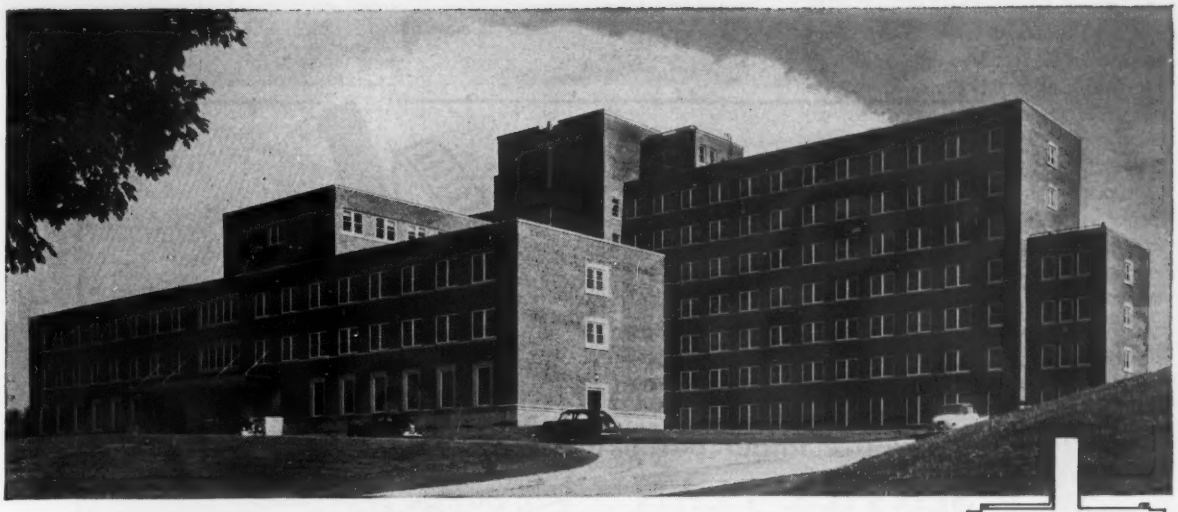
New circular saw

Taming one of the most savage of working tools is reported in *Safety Engineering* for May. The circular saw has long been a bad actor in terms of safety because so often it causes accidents that result in permanent disability.

The new saw blade, instead of having a large number of teeth, has only a few (usually eight) carbide-tipped teeth, arranged at regular intervals around the periphery of the saw. The article reports that the new saw design, besides increasing safety, results in a 30 per cent power saving.

The saw eliminates kickbacks that throw pieces of wood against the operator. While of course it does not entirely eliminate the cutting of flesh upon accidental contact, the severity of the cut is substantially reduced because a hand coming in contact with the blade could not be grabbed by the teeth and torn to pieces.—R.H.

Further information about products referred to in these columns may be obtained by writing to: HOSPITALS, Editorial Department, 18 E. Division Street, Chicago 10.



Georgetown University Hospital, Washington 7, D. C. Heated by 4-zone Webster Electronic Moderator System of Steam Heating. Architects: Kaiser, Neal & Reid, Pittsburgh, Pa. Consulting Engineer: F. J. Firsching, Pittsburgh. General Contractors: John McShain Co., Washington, D. C. Heating Contractors: Standard Engineering Co., Washington, D. C.

3-Year Heating Record

at Georgetown University Hospital

Report of Chief Engineer Sam S. Shepherd Georgetown University Hospital

"In my opinion, the Webster Moderator System embodies the best features to be found in controls for heating systems.

"As we have it here, the Webster Moderator System coupled with a properly installed zone system makes it possible for us to prevent underheating in severe weather and—even more important—we do not overheat in mild weather or during days with a normal variation in the outside temperature.

"My records show clearly that with the Moderator in use, the consumption of fuel for heating purposes follows very closely the degree day demand.

"This is encouraging to the operating engineer because he knows that here is a means to prevent waste of fuel from the very sources which are most prevalent in uncontrolled heating systems.

"Our installation is reasonably new. We are now in the third year of operation. Very few parts have been replaced and the control system is operating at peak efficiency."

How the Webster Moderator System meets comfort requirements without wasteful overheating has been demonstrated in the new Georgetown University Hospital.

With the Webster Electronic Moderator System, this well-managed institution enjoys "Control-by-the-Weather" comfort. Each of the 779 radiators gets heat in the amount needed.

The report on the effectiveness of the Webster Moderator System was made by Sam S. Shepherd, Chief Engineer of the Hospital since its completion in 1947 and prior to that Chief Engineer of Georgetown University. Careful operation and a vigilant maintenance program have been important factors in the success of the heating installation.

In choosing the Webster Moderator System, designers of Georgetown University Hospital did not experiment. Similar Webster Moderator Systems serve in such outstanding institutions as the U.S. Naval Hospital, Bethesda, Md., Delaware Hospital, Wilmington, Del., Our Lady of Lourdes Hospital, Camden, N. J., and many others.

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The need for a psychiatric unit in the general hospital

PRESENT IN THE world today are three distinct creeds as to the care of the mentally ill—totalitarian medicine, government medicine, and voluntary and private practice. Writing in the *Pennsylvania Medical Journal*, March 1950, Dr. Elmer L. Horst of Reading, Pa., comments that although 149 nongovernment general hospitals have established psychiatric units since 1902, government has had almost complete monopoly of one-half of all the hospital beds in the United States devoted to the care of the mentally ill during the past 100 years.

Although psychiatry has shown some indication of emerging from its status as the stepchild of medicine to that of a full-fledged partner, great encouragement to government medicine has developed through the establishment of complete psychiatric units in general medical and surgical hospitals of the 37 units of the Veterans Administration.

Totalitarian medicine is the most extreme form. In the late war, the philosophy in Germany was: Kill what you can't cure. This was done scientifically, and presumably euthanasia was explained by scientific factors.

The principle of state government care of the mentally ill rests upon the belief of the public and physician that the state will have to take responsibility for what cannot or will not be done. Quoting Dr. George S. Stevenson, president of the American Psychiatric Association, in 1947: "In the name of economy we have sold our heritage and allowed the state to prostitute psychiatry to the extent that patients do not have the free choice of physicians and are deprived of community contact. The ills of the mental hospitals are not the public's evil intent, but the heritage of an outworn system which is wasting money and opportunity. Under this system, which is so devoid of spirit, personnel of the best training and scientific inquisitiveness are not attracted, and this adds further to the isolation. The precursors and early stages of mental illness are left without attention in the communities in which they develop, and those patients who have recovered in the hospitals are returned home without guidance that convalescent patients should have."

Present indications are that the majority of state and some private mental institutions in this country do not meet standards of the American Psychiatric Association for professional personnel. Important therapies as insulin shock are largely neglected in many institutions. Treatment is delayed as much as three to six months. Within the first year, remission rates may decrease from 10 to 20 per cent.

Although the average cost of maintaining a patient in the mental hospital is $731 a year and the cost of operating state institutions for the mentally ill has increased approximately 600 per cent in the past 15 years, humanity and scientific treatment within the institutions are neglected, and the prevention of mental illness or the promotion of a higher level of mental health within the community is stunted.

Advocating care of the mentally ill in the voluntary hospital on the basis of modern private practice, the good physician is obligated at all times when he sees illness to do whatever is in his power to aid the patient, and he must not be precluded from utilizing the best method and treatment by the necessity of following an impersonal regime. The general hospital is the main healing agency in the community. It is the health center for prevention and treatment of illness, and the public has a right to expect provision of adequate facilities for all types of patients.

Cited as the advantages of a psychiatric unit in the general hospital are the following basic facts: One out of every 13 admissions to the medical wards of a general hospital will present personality disorders. Many problems are frequently encountered in patients in general hospitals which require consultation or the institution of therapy. The general hospital itself often treats psychiatric patients whom it refuses to recognize as such, often administering medieval punitive therapy which would not be allowed in a well-run psychiatric hospital. General hospitals need psychiatric services and facilities for the training of interns and student nurses.

DISADVANTAGES OVERCOME

The disadvantages of a psychiatric unit are largely administrative and can be overcome. Well-managed psychiatric patients are not more noisy than the average obstetric, pediatric or surgical patient. Suicides in the hospital are almost as prevalent as in mental institutions. Suicide is not a major objection. Although 50 per cent of patients admitted to state hospitals are dependent, others are marginal or comfortable in economic status. Minimum bed facilities are established by some authorities as an 18-bed psychiatric unit. It has been reasonably established that a psychiatric service with a minimum of 50 beds can sustain itself with patient income alone and at the same time take a limited number of free, part-pay and full-pay ward or semiprivate patients.

The following are essential to successful operation of such a unit:

1. An enlightened public policy.

2. A board of directors having faith in such a unit.

3. Competent supervision.

4. An adequately trained staff of psychiatrists, psychiatric nurses, psychiatric attendants, social workers, psychologists and clerks.

5. A specially constructed or remodeled unit. For such a unit to be self-supporting, it should have at least 30 beds. Psychotherapy of a dynamic type and psychosurgery are indicated in many instances. Although strict psychiatric principles must be observed, the family physician, community agencies and the family itself can give valuable aid. Frequently this is impossible in distant private or state hospitals.

The problem of the mentally ill today resolves itself not into whether or not we are being scientific or whether or not therapy is necessary. The problem is: Do psychiatric patients have the same rights as other patients? Do they have the right of free selection of physicians? Do they have the right to be treated in voluntary hospitals, or must they be treated in exclusive private hospitals or charitable state hospitals?

The following basic conclusions are offered:

1. The type and degree of therapy available to mentally ill patients depend primarily on deep moral principles. Pure scientific interest is not enough.

2. An increasing number of communities should offer psychiatric therapy to patients in community general hospitals.

3. The benefits to the community of the psychiatric unit in the general hospital, as well as the ancillary benefits such as intern and nurse training and community orientation are not without merit.

* * *

Status of internships

Intern and residency programs in hospitals approved by the American Medical Association's Council on Medical Education and Hospitals have increased during the past 10 years. The council's annual report, made public in the April 15 *Journal of the American Medical Association*, shows that there were 9,398 approved internships available as of April 1, 1950. This compares with 9,124 a year ago, and 7,998 in the prewar period of 1940. The increase of 814 approved internships over the last four years involves virtually the same number of approved hospitals—about 800—for both 1946 and 1950. This trend toward a greater demand for intern service is a significant factor in considering the present shortage of interns.

The federal services now provide 6.2 per cent of the internships offered by approved hospitals, with the navy listing 208, an increase of 19 over last year, and the army, 154, a decrease of three during the same period. These figures do not include army and navy internships in civilian hospitals. Federal Security Agency hospitals, including those of the Public Health Service, have 154 available internships, the same number as last year.

For the first time the council has listed Veterans Administration hospitals as approved for intern training. In the two hospitals approved as of April 1, 1950, there were 87 internships being offered. Other governmental hospitals, city, county and state, provide for 31.1 per cent of the internships, including 1,300 in city hospitals, 713 in county, 560 in state and 224 internships in city-county hospitals. Internships in nongovernmental hospitals comprise 62.7 per cent of the total, with nonprofit hospitals offering 3,184, church-sponsored hospitals, 2,405, corporation hospitals, 43, and hospitals conducted on a partnership basis, 11.

Internships unfilled last September 1 numbered 2,340, or about 25 per cent of the total offered. A year ago the vacancies reported numbered 1,779, or 19.7 per cent of the total.

In addition to the increase in approved internships, a significant factor in the present shortage of interns has been the decrease in the number of 18-month and two-year internships available, with a consequent increase in the annual demand for interns by hospitals which formally offered appointments only on alternate years.

The number of hospitals offering programs in excess of one year is 77. There are 1,189 rotating, 132 straight and 82 mixed internships offered, which were more than one year in length. This constitutes 15.6 per cent of the total number approved in reporting hospitals.

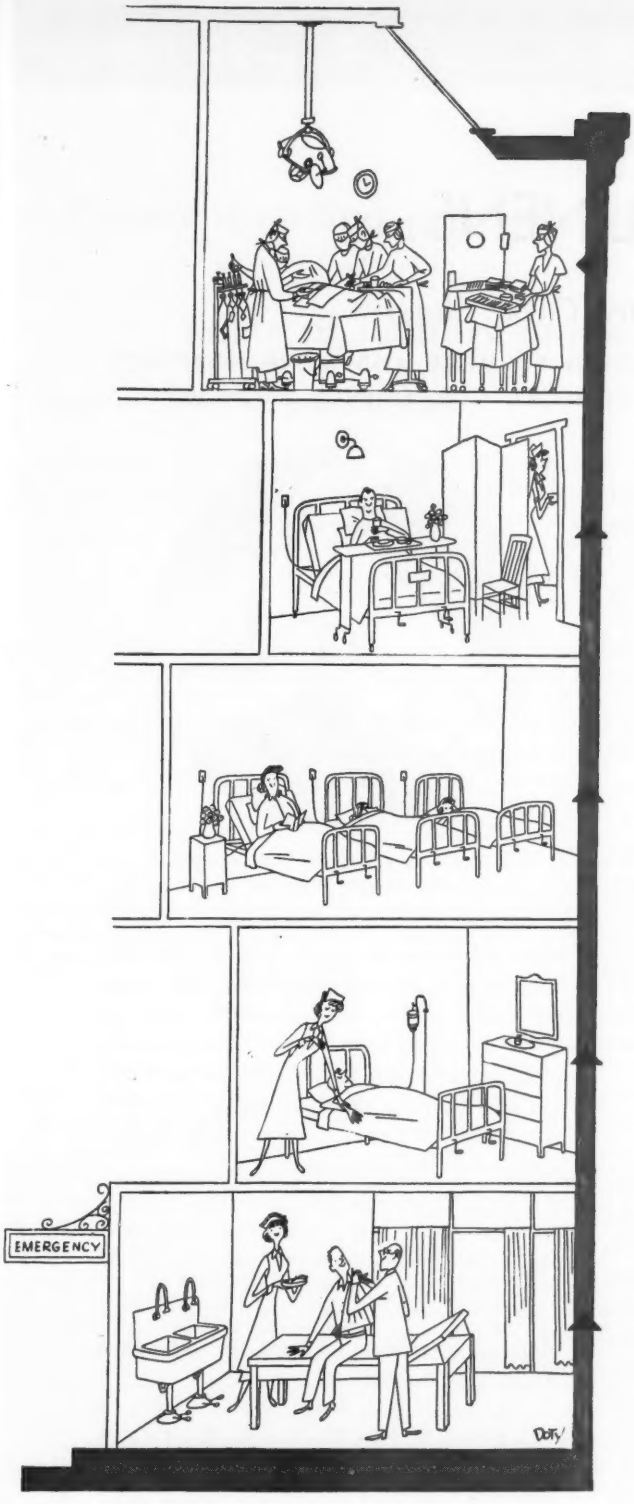
Reorganization of the internship on a two-year basis by 40 per cent of those hospitals presently approved would serve to reduce the number of interns required annually to approximately the number of interns available. The development of two-year programs designed for the physician intending to enter general practice and specialty board acceptance of internship training at the second year level, when feasible, would serve to stimulate renewed interest in longer training periods for interns.

APPROVED RESIDENCIES

Approved residencies offered physicians for further training in the specialties totaled 18,669 on April 1, 1950, as against 17,293 a year ago and 15,172 two years ago. There are 4,292 residency training programs now being conducted in 1,079 approved hospitals. The specialties for which there are the greatest number of approved programs are: Surgery, 600; internal medicine, 528; pathology, 417; radiology, 375; and obstetrics and gynecology, 374. The number of vacancies reported was 1,179, or approximately 6 per cent.

Surgical residencies are listed in two categories: (1) Those approved by the council and the American Board of Surgery (in which training now is required for a three or four year period in the same hospital) and (2) those in hospitals to which approval has been extended by the council as offering satisfactory training in general surgery acceptable in preparation for residency training in the surgical specialties. These appointments are offered for one or two years. Residencies in general practice are listed for the first time with 32 hospitals offering 94 residencies in this field.

The Medical Review department is edited by Charles T. Dolezal, M.D., secretary of the Council on Professional Practice.



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Proper spending can reduce the costs of laundry operation

FRANKLIN P. IAMS AND ROBERT P. JONES

ABOUT THREE YEARS ago, Rhode Island Hospital took a long look at the problem posed by its outmoded and costly laundry and evolved a plan. It was a long-range plan, with its goal at least six years away. There were to be heavy expenditures for renovating the laundry, $80,000 for new machinery and equipment alone. Other increased expenses were to come from higher wage rates and a thorough maintenance and repair program.

At the close of the fiscal year 1948-49, we were at the halfway mark. Although our expenditures had been heavy, as we had planned, a comparison of old and new cost and production figures showed that the net result has been an increase in output and a *reduction* in costs.

Few departments in a hospital lend themselves to comparative analysis on a unit-of-production or production-per-employee-hour basis. In most departments the economies which are effected through outlays for new equipment and through applying scientific management are quickly absorbed through the introduction of new services. Results are not very tangible; often they can be portrayed only in terms of increased service. Our recent study of the hospital's laundry operation, however, shows that here such efforts and expenditures can be measured more tangibly.

Before outlining the plan we are following, some description of the hospital and of the problem it faced should be given.

Rhode Island Hospital is an acute general hospital of 569 beds. Although it is a voluntary hospital, it serves also as a general city hospital for Providence. Inpatient admissions average approximately 15,000 annually, with an average daily census of 485. Outpatient visits average 45,800 per year, and accident department patients treated average 16,850 annually. In addition to the main hospital there is a children's wing; a pavilion for private patients; an outpatient clinic building; a large emergency and accident service; separate dormitories for house staff, student nurses, graduate nurses, male and female employees; and one 50-bed unit (for extended care for children) situated 18 miles from the city. There are 55 interns and residents and 200 student nurses housed in their respective dormitories.

In 1946 the hospital's laundry, working at full capacity, was processing 140,880 pounds of linen per month. This was barely enough to meet the needs of the various nursing units and departments. Soiled linen backlogged in the laundry daily. Complaints of linen shortages were the rule rather than the exception. Relations between the nursing department and the laundry were none too good, and understandably so. The laundry equipment was old, outmoded, and in poor repair following the war. Most machines were 20 or more years old; many of them had been purchased second hand. A total of 54 persons, hampered by frequent breakdowns of equipment and serious production bottlenecks, were employed in the department. This included those engaged in pickup and delivery of linen as well as supervisory personnel.

Production was low and the cost was high. For those employees actually engaged in laundry operations, the production per employee hour was a scant 16.3 pounds, and the cost per pound of linen processed was 4.31 cents, which did not include indirect costs.

Faced with this already serious linen supply problem, the hospital also had to consider other factors. The number of hospital admissions was steadily increasing. The average length of stay was decreasing. Both seemed to indicate an increased demand for clean linen, hence an increase in laundry volume. In addition, plans for new hospital construction called for 100 additional beds. This would further increase demands on what appeared to be an already overtaxed laundry.

EVOLUTION OF PLAN

This problem was discussed at numerous meetings of the director, his assistants, the laundry manager and the superintendent of buildings and grounds. In these discussions all factors bearing on the hospital's laundry needs were reviewed and several conclusions were reached.

1. The present laundry building was determined adequate, as far as space was concerned, for both present and future needs. Handicaps of layout within the building could be overcome to a large degree. Planned new construction would free other buildings which could be adapted readily to laundry use, at a minimum of expense, if that were determined necessary.

2. The present laundry was overstaffed and underequipped.

3. A rejuvenated repair and maintenance program could carry much of the old equipment through a longterm replacement and modernization period.

4. A revitalized leadership, a higher quality of employee, an employee-training program, intelligent supervision and improved procedures could result in increased production and lower unit costs.

After we arrived at these conclusions, a machinery replacement program amounting to approxi-

Mr. Iams is assistant to the director and Mr. Jones is laundry manager, Rhode Island Hospital, Providence.

Savings through spending

Below is a comparison of operating costs and output for the Rhode Island Hospital laundry during fiscal years 1946-47 and 1948-49.

	1946-47	1948-49	% increase or decrease
Direct costs[1]	$72,675	$69,176	− 4.8
Pounds of linen processed	1,690,581	1,827,663	+ 8.0
Cost per pound[2] (direct expense only)	4.31c	3.78c	−12.6
Number of employees[3]	54	38	−29.6
Salaries	$66,005	$61,089	− 7.4
Average salary per employee	$1,222	$1,607	+23.9
Production per employee hour in pounds	16.3	26.2	+60.0
Number of patients admitted	13,702	14,924	+ 8.9
Number of operations	9,972	11,163	+12.0
Pounds of linen per patient day	9.5	10.4	+10.0

1. To secure a basis for comparison, new equipment costs have been deleted from these figures.
2. If it is estimated that indirect costs would add 50 per cent to this figure, total cost per pound would amount to about 5.6 cents. A recent study of 28 hospitals in Massachusetts by an auditing firm arrived at an average cost per pound of 6.7 cents. The bed capacity of these hospitals ranged from 51 to 797 beds. Those hospitals over 200 beds had costs per pound ranging from 5.0 cents to 9.9 cents. Large teaching programs, such as the one at Rhode Island Hospital, increase the percentage of "finish work", which is reflected in a higher average cost per pound.
3. The ratio of employees to laundry volume is perhaps greater at Rhode Island Hospital in that here the delivery and collection duties are assigned to the laundry, whereas in many hospitals these duties are classified as housekeeping and charged to that budget.

mately $80,000 was drawn up; presented to the hospital's board of trustees, and approved. We then included the replacement program in a six-point plan for improvement of our laundry operation.

A review of our progress during the past three years will serve well as an outline of this plan.

First, we have increased laundry employee salary ranges. This has permitted us to hire better quality personnel, to initiate an employee-training program which offers better wages as an incentive, and to create a competitive spirit, a departmental loyalty, and a high morale which formerly did not exist. The result has been a decided increase in production per operator-hour.

Second, in most instances, we have not replaced employees who resigned but have reassigned their work to others through job reclassification. This has permitted those who remain to feel more responsible and in most cases has given them increased wages. The result has been a reduction in the number of employees from 54 to 38 in three years' time. (Of this number, two are engaged in supervision and three in pickup, delivery and porter service.)

Third, we have purchased new machinery totaling approximately $35,000 (with one new $5,000 item just coming in the door). The original replacement program amounting to $80,000 will not be complete for three more years. Already, however, we find that this step has eliminated the bottleneck in the extracting operation and that flatwork ironing and folding moves more smoothly. In addition, we have found that the new machinery has helped make possible the reclassification and combining of old jobs and has reduced maintenance cost and time lost because of breakdowns.

Fourth, we have thoroughly repaired all old machinery and instituted a preventive maintenance program. Neglect and the need for improvising during the war years made this a costly step during the first two years of our program. Now, however, periodic servicing is about all that is needed to prevent major breakdowns and to keep linen flowing through the laundry. Further operating economies will be realized as the remaining old equipment is replaced by new.

Fifth, we have made flow charts tracing all classifications of linen through the various laundry processes. Production bottlenecks and crisscrossing of flow lines are being eliminated as a result. Motion and time studies are resulting in the refinement of procedures and the saving of many lost hours.

Sixth, and vitally important, we have established a sound working relationship between the laundry and the nursing department. Formerly, steps taken in the laundry to streamline linen-folding operations and to eliminate various finishing processes resulted in increased work at the bedside. Linen delivery schedules were at the convenience of the laundry. Today, following an intensive program of conferences between head nurses and the laundry manager, procedures governing linen processing, delivery schedules, linen standards and control have been jointly determined and are designed to meet the needs of the nursing units. This has been an educational program and has placed an important role in reducing lost time and in improving employee morale.

With the plan 50 per cent complete, a review shows that today our laundry is providing more clean linen per day to an increased number of patients, nurses and house staff members and is providing it at lower cost with considerably fewer employees. Detailed analysis shows that:

1. The laundry is operating with approximately 30 per cent fewer employees.
2. Employee production is up 60 per cent.
3. Total output is up 8 per cent.
4. Ten per cent more linen is provided for each patient because of the higher ratio of acutely ill patients.
5. Average salary per employee is up 23.9 per cent.
6. Direct operating costs are down by about 5 per cent.
7. Production costs per pound are down by 12.6 per cent.
8. Salary costs are down by 7.4 per cent.

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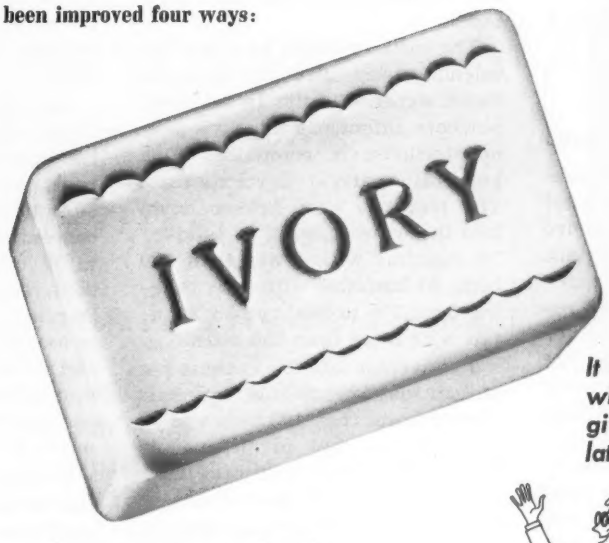

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our laundry personnel complement would have remained the same or would have been increased to handle the present production. It would have cost the hospital about $39,000 more in salary costs for this past year alone. These improvements in laundry operation, resulting in part from new machinery, have more than saved the expenditure for that machinery.

As production costs have fallen, laundry service to the units of the hospital has increased in almost inverse proportion. There is now ample linen to fill requisitions. The backlog of linen in the laundry is clean, not soiled. Complaints from various units of the hospital, which formerly were averaging more than 30 a day, now have dwindled to a trickle. The one or two calls per week that the laundry does receive more often than not concern corrections or additions to a laundry requisition. Relations between the nursing department and the laundry are good.

CONTINUING TREND

Our laundry production figures for the first six months of this fiscal year ran 12 to 14 per cent above those of the same period last year. During this same period, the number of employees was further reduced from 38 to 35. The figures for the month of March 1950 show that the trend of our direct operating costs is continuing downward. Our direct costs per pound for the same month decreased to 3.17 cents, or 15.7 per cent lower than our costs during the year 1948-49, and our production per employee hour now is up to 30.7 pounds, representing a further increase of almost 15 per cent over last year.

Our current production per employee-week is about 1,350 pounds. The best commercial laundries, with completely mechanized procedures, high wage levels and incentive programs, are striving for 2,000 pounds per employee-week on a 40-hour-week basis. If we can continue to streamline production methods and continue with our machinery replacement program for the next three years, as planned, we will more nearly approach this level of production and thus be able to show considerable further reduction in laundry unit costs.

LAUNDRY MANAGEMENT COMMENT

109 cost comparisons

NOT LONG AGO the Public Health Service was interested in assembling meaningful departmental cost comparisons for various sizes of hospitals. With the assistance of William H. Markey Jr., the Association's accounting specialist, 109 hospitals were selected from a large group using the governmental reimbursable cost formula.

Laundry managers should find these comparisons helpful since the accounting for the hospitals chosen was judged to be accurate and suitable for comparison purposes.

The costs reported were for the calendar year 1948 and included direct expenses only. In addition, newborn infant patient-days were not included in computing each hospital's patient-day expenses. The hospitals were broken down into three size groups, as follows: 36 hospitals with fewer than 100 beds, 45 hospitals with beds ranging from 100 to 249, and 28 hospitals with more than 250 beds.

The average laundry expense per patient day in the 36 hospitals having fewer than 100 beds was 50 cents—4 per cent of an average total patient day cost of $12.64. Laundry expense for the next group, 100 to 249 beds, averaged somewhat less, 47 cents per patient day and 3.5 per cent of a total patient day cost of $13.36. Lowest patient day laundry expenses of all were in the 28 hospitals with more than 250 beds. Laundry expense per patient day averaged only 43 cents, and made up only 3 per cent of an average total patient day cost of $14.43.

Although the average laundry expenses for hospitals in these three groups were comfortably close, there were wide variations when the groups were broken down into cost percentiles.

Greatest uniformity in patient day laundry expenses appeared in the 45 hospitals with 100 to 249 beds. Only one reported patient day laundry expenses lower than 20 cents and none higher than 79 cents. Twelve reported expenses ranging from 30 to 39 cents; 10 from 40 to 49 cents, and 11 from 50 to 59 cents. Only eight showed laundry expenses in excess of 59 cents a patient day.

The greatest variation in laundry expenses appeared in the large hospital group. One hospital reported only four cents a patient day, and another reported from 80 to 89 cents a patient day. The 26 others were well distributed over the percentile range. Only seven fell into the same bracket as the statistical average for the group—40 to 49 cents.

As would be expected, generally higher expenses were reported from the hospitals with fewer than 100 beds. Although the average was 50 cents a patient day, the greatest concentration (11) fell into the 30 to 39 cent bracket. Only two of them reported expenses of less than 30 cents per patient day, compared to four for the medium-sized group and six for the large. Eight of these hospitals had expenses of 70 cents and higher per day, and two were in the 90 to 99 cent bracket.

Considering the select nature of this group of 109 hospitals, it is significant that the variations are so marked. How much more so would they be for hospitals chosen at random?

Such studies as this emphasize the need for more uniformity in laundry accounting methods, as well as for a thorough on-the-job soul searching by laundry managers.

Two Association publications should be of distinct value in promoting these ends: For the laundry manager's working efficiency—*Hospital Laundry Manual of Operation;* for selection and recording of pertinent laundry costs — the soon-to-be published departmental cost accounting section of the new accounting handbook.

Dr. L. Samuel Sica
General Drive Chairman

SALUTE TO THE STAFF DOCTORS OF TRENTON'S ST. FRANCIS HOSPITAL

LAWSON ASSOCIATES congratulates the staff doctors of St. Francis Hospital in Trenton, N. J.

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Dr. George N. J. Sommer
Honorary Drive Chairman

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So we say again—congratulations to the staff doctors of St. Francis Hospital. Congratulations to Dr. L. Samuel Sica, Medical Division Chairman; Dr. George N. J. Sommer and Dr. Horace D. Bellis, Honorary Chairmen, and their campaign workers.

They've shown the way for the people of Trenton and Mercer County, N. J. who will be asked to contribute the remainder of the $1,000,000 goal this fall.

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The history, causes and effects of nationalized medical care

COMPULSORY MEDICAL CARE AND THE WELFARE STATE. Melchior Palyi. 156 pp. Chicago: National Institute of Professional Services, Inc. 1950. $2.

THE HISTORY of nationalized medical care, in practically all the countries that have tried it, has followed a somewhat similar path. From small beginnings it has expanded, and as it has grown in size it has grown also in importance as a political plum. Its idealistic purpose — better health for all the people—has been subjugated, almost without exception, to a more ulterior purpose: More power for those in control. And with that power has gone a deterioration in the quality of medical care for the almost-forgotten patients and a professional deterioration of those who provide the actual services.

Melchior Palyi's book traces these historical developments and gives the reader a picture of the thinking behind them.

His 40 years in Europe, his experience as student, teacher and economist have given Mr. Palyi a unique background for this project. He was a student and assistant of Lujo Brentano and Max Weber, leading social scientists of the Bismarck age, and he served as chief economist to the Deutsche Bank in Berlin and as scientific adviser to the Reichsbank of Germany. He taught at the Universities of Kiel, Goettingen and Berlin. In America, he has taught at the Universities of Chicago and Wisconsin and at Northwestern University. In 1948 and 1949 he made two trips to Europe to study developments in compulsory medicine.

Three significant points stand out in his work:

(1) Compulsory medical care is fundamentally different from every other branch of social security in that it provides benefits in service instead of cash.

(2) Up-and-coming dictators have traditionally opposed existing compulsory health schemes—and then have become their ardent supporters once in control.

(3) Nationalized medical programs traditionally foster bureaucracy, patronage, waste, restrictive controls and inefficiency.

In some respects, the book does not live up to the expectations that one might have of an author with the background of Mr. Palyi. While his historical reporting is comprehensive, it is not ideally organized, and his presentation sometimes is difficult to follow.

Notably lacking is a solution—a suggested alternative. This, of course, could make two or three books in itself, and Mr. Palyi undoubtedly avoided the subject intentionally. The reader who feels let down at this absence of a suggested solution must re-read the title—"Compulsory Medical Care and the Welfare State."

The main value of this book seems to lie in its gathering together of the history and philosophy behind most of the world's experiments with nationalized medicine. This material can be useful in the fight against government medicine in the United States, and the months and years to come should see it referred to many times in the offices and cloakrooms of Washington.—A.A.R.

Inquiries about books reviewed in the Literature department should be addressed to the American Hospital Association Library — Asa S. Bacon Memorial, 18 E. Division Street, Chicago 10. The department is edited by Helen V. Pruitt, librarian.

History of transfusions

BLOOD TRANSFUSION. Edited by Geoffrey Keynes. Baltimore: The Williams and Wilkins Company. 1949. 574 pp. $12.50

A comprehensive study of the history of blood transfusion and a review of the current practices in England has been released for publication in this country. Most of the material is of a technical nature and of interest primarily to hematologists. The first chapter, on the history of blood transfusion, is of general interest and information, however. Two chapters—one on the storage and preservation of blood and blood derivatives and the other on the organization of a hospital transfusion department—describe the procedures as established in the English hospitals. Comparison of these techniques with those in the United States may be made by persons working closely with the problems of blood and plasma banks. The English hospitals have standardized the classification of blood groups, and this text contains a chapter on blood groups, with a following chapter on the RH blood group.

Each chapter has been written by an authority in that specific phase of blood transfusion.—H.V.P.

Children's convalescence

REPORT OF STUDY ON THE JUNIOR LEAGUE HOME FOR CONVALESCENT AND CRIPPLED CHILDREN, Tulsa, Okla. Submitted by the Children's Bureau, Federal Security Agency, Region VIII, Dallas, Texas. 1950. 83 pp.

The study of this convalescent home came about through the request transmitted to the bureau through the state crippled children's agency. The report deals with the specific problems of a convalescent home that had already been in operation. The introduction to the published report states that many of the recommendations made in the survey conducted in 1949 already have

been adopted and that a board of trustees for the home has been appointed. The general principles and policies set forth for the administration of the home are applicable to similar institutions and will be especially helpful to those interested in developing a new convalescent home for the care of children discharged from an acute general hospital.

The place of the community and its responsibility for the continuing care of these children also is discussed. The recommendations are most specific and the appendix includes a chart of organization, the by-laws, requirements of the professional staff, administrative practices and procedures.

A comprehensive bibliography adds to the resourcefulness of the book.—H.V.P.

Plant maintenance proceedings

There is no reason why good maintenance ideas developed for industry cannot be used to some extent in the improvement of hospital maintenance. For this reason many engineers will be interested in the published proceedings of the First Plant Maintenance Conference, which was held in Cleveland in January.

These proceedings have been reproduced and are available for sale at a price of $2. One of the lectures—that given on industrial plant sanitation and housekeeping, by the sanitary engineer of a large baking company—provides many ideas that in one way or another are applicable to the hospital picture. This publication should be in the library of the hospital engineer and commends itself to his careful reading.—R.H.

Public affairs pamphlets

Hospital administrators are frequently on the lookout for material on health subjects which may be given or recommended to patients and to lay groups in the community. The Public Affairs Committee, Inc., 22 East 38th Street, New York City 16, has published and distributed some three million pamphlets on health since its organization as an educational nonprofit agency.

There are now 19 titles in the health series, and two more are scheduled for fall and winter publication—one on "Arthritis and Rheumatism" and the second on "Hardening of the Arteries and High Blood Pressure."

Some of the booklets most in demand have been "Blood's Magic for All," "Facing the Facts About Cancer," "How Shall We Pay for Health Care," "Mental Health Is a Family Affair," "Make Your Town Safe," and "Live Long and Like It." Each costs 20 cents.—H. T. Y.

Routine chest x-rays

THE IMPORTANCE OF THE HOSPITAL AS A TUBERCULOSIS CASE FINDING CENTER. The Hospital Council of Greater New York and the New York Tuberculosis and Health Association. 28 pp. 1950.

A study of the current practices of hospitals in New York City with regard to chest x-rays of patients on admission was conducted in 138 of the metropolitan hospitals, and this report contains the findings of this study. Donald E. Porter, director of the Tuberculosis Division of the New York Tuberculosis and Health Association was in charge of the study.

The report points out that the number of cases of tuberculosis that may be discovered by this means is "anywhere from two to 10 times greater than that found in a community survey of similar numbers."

Comments by the directors of the two agencies stress the importance of this type of mass radiography. Dr. John B. Pastore, executive director of the Hospital Council of Greater New York, is quoted as saying, "Evidence clearly demonstrates that the x-raying of the chest should be included as a routine procedure for all admissions to hospitals." Dr. Herbert R. Edwards of the New York Tuberculosis and Health Association stated, "Public health authorities agree that the hospital is one of the best single locations in which to conduct a case finding program. In handling what is usually considered a health activity, hospitals should receive adequate financial support from public health funds earmarked for this purpose."

Six advantages of establishing such a program are outlined and then discussed in detail in the report. Tabulations of the results of the case finding now being conducted in the New York hospitals provide illuminating information on the results obtained.

Hospitals considering the inauguration of such a program will find much of interest and encouragement in this report.—H. V. P.

Nursing school facts

SCHOOLS OF NURSING IN THE UNITED STATES. 47 pp. 1950. Available from the Committee on Careers in Nursing, 1790 Broadway, New York 19.

A very helpful booklet to answer questions about the status of individual schools and to find the names of schools in a given locality has been compiled as an informational tool to assist in recruiting prospective students. There is also a list of the addresses of state boards of nurse examiners.—H. V. P.

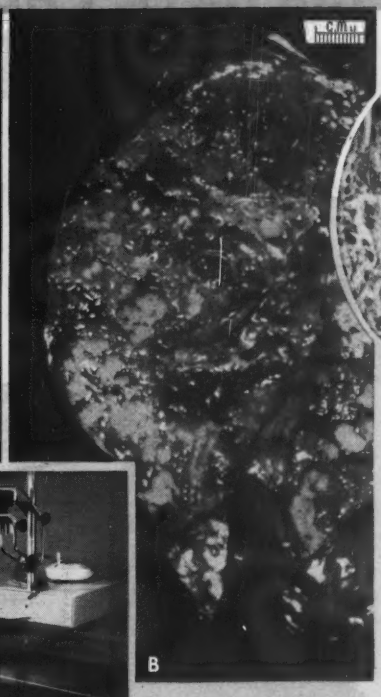
Childbirth with understanding

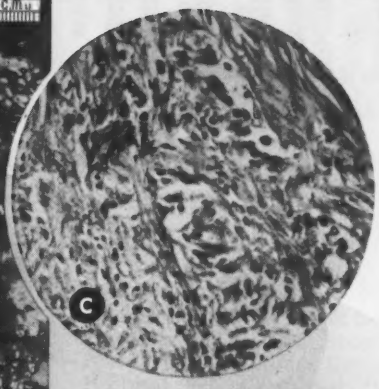
TRAINING FOR CHILDBIRTH; A PROGRAM OF NATURAL CHILDBIRTH WITH ROOMING-IN. Herbert Thoms, M.D. New York: McGraw-Hill. 1950. 114 pp. $3.

Dr. Thoms, who is professor of obstetrics and gynecology at the Yale University School of Medicine and obstetrician and gynecologist-in-chief at the Grace-New Haven (Conn.) Community Hospital, has written a report on the details of the program as it has been in operation at the Grace-New Haven Hospital and on the degree of success achieved. The author emphasizes that the training program is directed toward childbirth with understanding and support rather than the popular conception of "childbirth without fear."

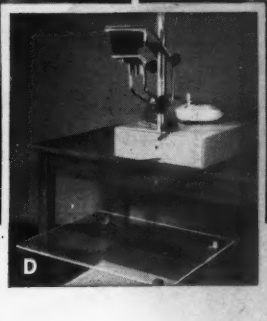
Dr. Thoms concludes that a better understanding, on the part of the patient, of the physiologic processes of pregnancy and labor increases confidence and reduces anxiety. The use of physical therapy techniques aids in the muscular effort of labor. Hospital administrators will be especially interested in the chapter on rooming-in, in which some of the advantages are outlined as well as the observations of the author as he has seen the practice carried on within the Grace-New Haven Hospital.

Dr. Thoms has had a great deal of experience in medical journalism and the book is exceptionally well written.—H.T.Y.

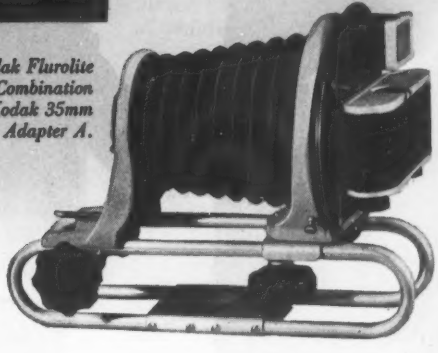




Reproductions **A** *and* **B** *show gross aspects of diseased lung after pneumonectomy. Reproduction* **C** *shows photomicrograph made from histological section of affected lung. Figure* **D** *shows setup of Kodak Flurolite Enlarger fitted with Camera components for the photography of gross specimens.*



Kodak Flurolite Camera Combination with Kodak 35mm Film Adapter A.



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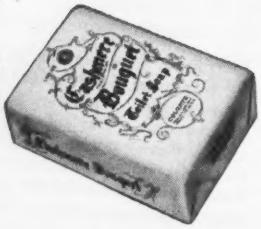

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PERSONAL *News*

DONALD CARNER has been named administrator of Parkview Memorial Hospital, a 200-bed institution now being constructed at Fort Wayne, Ind.

A member of the American College of Hospital Administrators, Mr. Carner was assistant administrator of Northwestern Hospital, Minneapolis, and prior to that he served as administrative assistant for the Commission on Hospital Care.

DR. JAMES C. HASSALL has retired as medical director of Rogers Memorial Sanitarium, Oconomowoc, Wis., after 13 years of service. He has been succeeded by DR. OWEN C. CLARK. Prior to his appointment as medical director, Dr. Clark was a member of the staff at Sacred Heart Sanitarium, Milwaukee.

ELEANOR BRESNAHAN, R.N., director of Alton Road Hospital, Miami Beach, has returned as administrator to Victoria Hospital, Miami. Mrs. Bresnahan previously served as administrator of that institution from 1936 to 1947.

The Alton Road Hospital now is known as the Mount Sinai Hospital.

ROBIN CARL BUERKI, JR., assistant director at St. Luke's Hospital, New York City, became director of the Valley Hospital, now being constructed in Ridgewood, N. J. A member of the American College of Hospital Administrators, Mr. Buerki served his administrative residency at St. Luke's Hospital.

BRUCE JULEON has been named superintendent of City Municipal Hospital, Gladewater, Texas, formerly known as McKean Clinic Hospital.

Prior to this appointment, Mr. Juleon held administrative positions with hospitals in Houston, Bryan, Rosenberg and Waco. He is a member of both the American Hospital Association and the Texas Hospital Association.

DR. DEAN W. ROBERTS has been appointed to the newly created position of deputy director of the Maryland State Department of Health. Dr. Roberts formerly was director of the state health department's Bureau of Medical Services and has served as assistant in pediatrics at the Johns Hopkins University School of Medicine, Baltimore. He was also an administrative consultant to the Maryland State Department of Education.

DR. W. R. SLATKOFF, assistant superintendent (medical) of Montreal (Quebec) General Hospital, resigned May 31 to become executive director of Maimonides Hospital, Brooklyn.

DONALD M. COX, secretary and manager of the Winnipeg (Man.) Municipal Hospitals, has been appointed assistant commissioner in charge of hospital services for the Hospital Insurance Service of British Columbia. He has been succeeded in his former position by JOHN M. MCINTYRE, assistant secretary-manager of Winnipeg Municipal Hospitals.

MR. McINTYRE

MR. COX

Mr. Cox is vice president of the Manitoba Hospital Association, past-president of the Upper Midwest Hospital Conference, and a member of the American College of Hospital Administrators. He had served with the Winnipeg Municipal Hospitals for the past 18 years.

Mr. McIntyre became secretary and manager of that institution on June 1. He is chairman of the finance committee of the Western Canada Institute for Hospital Administrators and Trustees.

ROBERT L. ZUCKER has succeeded E. J. LINCKE as administrator of Massillon (Ohio) City Hospital. Mr. Zucker was administrator of the Union Hospital Association, Dover, Ohio, and before that he was assistant director of Aultman Hospital, Canton, Ohio.

WILLIAM H. THRASHER became assistant director of John D. Archbold Memorial Hospital, Thomasville, Ga., on May 15. He had previously served as hospital field representative of the Division of Hospital Services, Georgia Department of Public Health, Atlanta.

JOHN W. ETSWIELER, JR. was scheduled to become assistant director of Malden (Mass.) Hospital on July 1. He succeeds JAMES V. DEVINE, who is now administrator of Webber Hospital, Biddeford, Maine. Mr. Etswieler recently completed his administrative residency at Malden Hospital.

WILLIAM I. FENDER became superintendent of Jay County Hospital, Portland, Ind., June 1. Prior to this appointment, he was assistant comptroller of Presbyterian Hospital, Chicago.

JAMES C. DAVIE, administrator of Tallahassee (Fla.) Memorial Hospital, resigned on June 5. He plans to enter into general practice of law in St. Petersburg, Va.

LEWIS A. HEGHIN, administrator of George B. Wright Memorial Hospital, Fergus Falls, Minn., has become administrator of the Doctors Hospital, now being constructed in Lincoln, Nebr.

MYRTLE LAMBERT became business manager of the Cornwall (Ont.) General Hospital on June 19. Prior to this appointment, she served as secretary at McKellar General Hospital, Ft. William, Ont.

IRENE G. MCCARTHY has been appointed acting superintendent of Henry Heywood Memorial Hospital, Gardner, Mass. She succeeds WINNIFRED E. CAMERON, R.N., who had served as superintendent of that institution. Miss Cameron

(Continued on page 126)

"Our Baking and Roasting Ovens Prove that

GAS is the most Versatile and Economical Fuel

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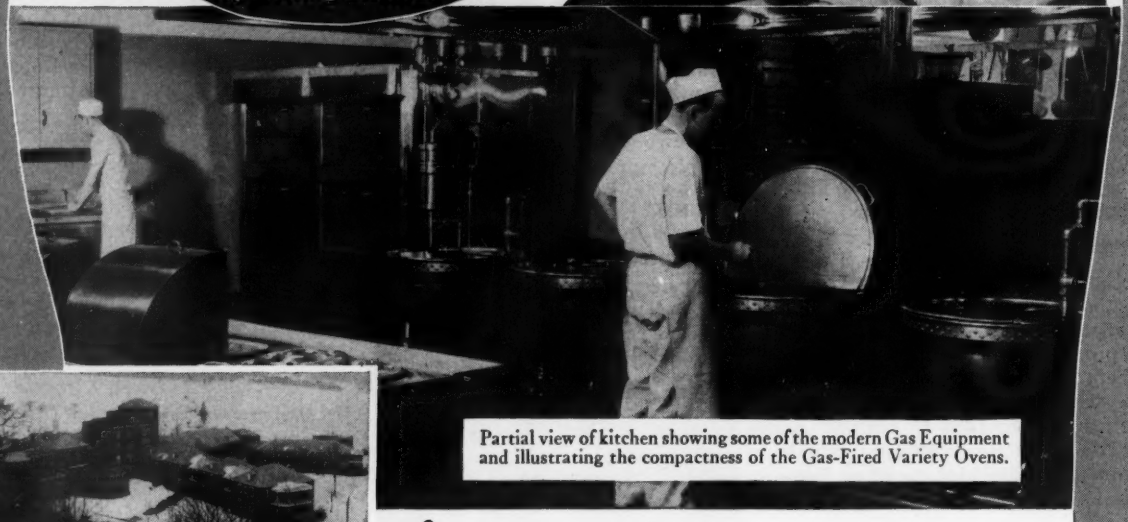
A. Lucille Brooks,
Supervising Dietitian



Partial view of kitchen showing some of the modern Gas Equipment and illustrating the compactness of the Gas-Fired Variety Ovens.

Homer Folks Tuberculosis Hospital
Oneonta, New York.

Unloading bread from two-section
Martin Variety Oven.

MULTI-PURPOSE PERFORMANCE is a pretty important factor in the selection of kitchen equipment for volume food preparation—the kind of flexibility you find in the modern Gas Ovens at Homer Folks Tuberculosis Hospital, Oneonta, New York.

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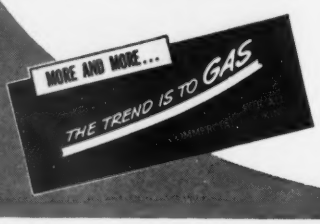
Today is a good day to call your Gas Company Representative for a check-up on modern Gas Equipment.

Illustrations and information furnished by Martin Oven Company, Inc., Rochester, New York, manufacturers of Gas-fired Variety Ovens.



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Some procedures for establishing a hospital dietary department

WILMA F. ROBINSON

AMONG THE FACTORS involved in establishing a dietary department in a new hospital are the numerous decisions to be made in regard to routine practices and procedures. Before the hospital is opened, careful consideration of these decisions and the formulation of a preliminary plan for operation will help to forestall many "opening day difficulties."

Since the procedures to be considered are based on the responsibilities of the person in charge of the department, it seems logical to begin with a review of her qualifications and duties. Margaret Mitchell, in a recent article,[1] has suggested two qualifications for a food service director in addition to the necessary formal education. These qualifications are: "A scientific knowledge and appreciation for top quality food, and the ability to work with and lead people."

That the hospital dietitian may have need for these capacities is indicated in the following summary of her responsibilities: Administration of the general food service; scientific management of therapeutic diets; education of the student nurse and/or dietetic intern; and formulation, for the hospital administrator's approval, of rules and regulations pertaining to practices and procedures within the dietary department.

In order to carry out her responsibilities the dietitian must have established policies on which to base a plan of operation. These procedures that should be considered before the hospital is opened are as follows.

Miss Robinson is consultant dietitian for the Illinois Department of Public Health, Division of Hospital Construction and Services, Springfield. This article is adapted from a paper presented at the Institute on Hospital Establishment, Chicago, January 1950.

PATIENTS' FOOD SERVICE

Type of menu (selective or nonselective): The selective menu may promote patient satisfaction, may eliminate the need for special diets based on patients' likes and dislikes, may save food, as the patient usually will order only what he likes and intends to eat, and may provide more accurate information in regard to the amounts of food to be prepared. It will, however, involve the preparation of a greater variety of food and will require personnel for menu distribution and menu summaries. In the instance of menu distribution and collection, the cooperation of the nursing department probably will be required. The nonselective menu is used successfully in many hospitals but does not have the advantages listed above.

Foods to be allowed on standard hospital diets: At least a temporary decision should be reached in regard to the foods to be allowed on the normal, soft and liquid diets. Suggested lists should be submitted to the medical staff for approval. The present trend is toward more liberal allowances insofar as variety is concerned. Usually there are no restrictions on a normal, or general, diet. Light diets, which seem to vary greatly in content, are now generally omitted, and on a soft diet the patient usually is allowed young tender whole vegetables instead of the unpopular vegetable puree. Liquid diets usually are classified as clear liquid or full liquid.

Between-meal feeding (nourishment): Here again the medical staff should be consulted. The trend is toward the reasoning that patients receiving a full or general diet do not need between-meal feedings unless the evening meal is served so early that the period between supper, or dinner, and breakfast is unusually long. A bedtime nourishment is often greatly appreciated by the patient. A policy will be needed regarding charges for nourishments not generally allowed.

Time schedule for tray service: The schedule set for tray service will depend largely on nursing routines. Patients usually prefer that breakfast and the evening meal be served as late as possible. This decision is important also as the dietary employees' hours on duty must be planned accordingly.

Time that dinner will be served —noon or evening: Common practice in the community or area should be considered. In rural areas patients usually prefer dinner at noon, and in urban areas they would rather eat it in the evening. Another factor to be considered is the availability of sufficient personnel for dinner preparation at the time decided upon.

METHOD OF DISTRIBUTION

Type of service or method of distribution: This is always a controversial subject, but the method of tray distribution usually is indicated by the facilities provided. The type of service most frequently planned for hospitals of 100 or fewer beds is a centralized service. In larger hospitals a decentralized service often is decided upon, although both types are used. The most important factor in any method of food distribution is the period of time between the serving of the food and the delivery of the tray to the patient. This period of time should be as short as possible. With modern equipment any method can be used successfully if the procedures are well organized and there is cooperation of all personnel involved.

Responsibilities of the nursing department in tray service: These responsibilities will depend on the method of tray distribution. Nursing personnel probably will deliver

the completed tray to the patient where there is a decentralized service. It was formerly common practice for the nurse to serve the food also, but the dietary department has assumed this responsibility in most instances. Supervision usually is facilitated if dietary employees are used for as much of this service as possible. It is well to clarify any division of responsibility so that both departments know definitely the extent of their responsibility. Attention should be called to the importance of having patients ready to receive their trays on time so that they can eat before the food has an opportunity to become cold.

GUEST TRAYS

Guest trays served in patient's room: A definite decision in this regard may be deferred until the number of probable requests is determined and it is possible to tell whether or not adequate personnel is available to give this extra service. The possibility of such requests, however, should be recognized. This service may be limited by serving trays only on the recommendation of the doctor or head nurse. If guest trays are served, the amount to be charged for the tray should be established.

Meal census: A method of obtaining the meal census must be determined. The meal census should be an actual count of meals served and not a figure based on patient days. The American Hospital Association's "Handbook on Accounting, Statistics and Business Office Procedures for Hospitals"[2] suggests the following meal census records:

1. Meals served hospital patients (excluding nourishments and formulas prepared for infants)—recorded by class of patient and subclassified according to regular diets and special diets.

2. Nourishments served hospital patients—recorded by class of patient.

3. Formulas prepared for infants—classified as newborn infant, nursery formulas and others. (If formulas are prepared by the nursing department, such department should submit these statistics.)

4. Meals served hospital employees. This classification should include only meals actually provided employees as perquisites. Meals sold employees should be included in the count of units of service applicable to the pay cafeteria or restaurant.

5. Meals served special nurses.

6. Meals served guests and relatives of patients.

7. Meals served (sales) in pay cafeteria, restaurant or tea room.

Policy for handling complaints: It is well to recognize the fact that there will be complaints concerning food and that they are often constructive criticism. It is worthwhile to develop an attitude among the staff that criticism used objectively for the improvement of the service will pave the way for compliments.

Policy regarding the routine visiting of patients by the dietitian: The practice of the dietitian's visiting all patients in the hospital promotes good public relations, but it takes time and should be taken into consideration in the planning of her schedule. Some of the responsibility might be delegated to someone else in the department.

PERSONNEL FOOD SERVICE

Type of menu (selective or nonselective): This decision will depend somewhat on facilities and available personnel. If a selective menu is offered to patients, it should not be too difficult to offer a selection to the employee group also. A selective menu usually promotes employee satisfaction, and the variety need not be extensive. In hospitals where employees are provided meals as perquisites, a nonselective menu usually is offered. In the pay cafeteria some selection is necessary. The type of menu to be served for the night supper must be considered. This may be a full meal or a snack, depending upon the desires and requirement of those to be served at this time. Available personnel for the preparation of this meal also will have to be considered.

Type of service: This question is decided, to a great extent, by the physical facilities provided. Cafeteria service is the most popular type at the present, especially in the new hospitals. In the smaller hospital a self-service arrangement may be provided in the main kitchen. The cafeteria may be a pay or nonpay type.

Time schedule for meal service: This schedule will be affected by the tray service schedule and the hours on duty set for personnel.

Personnel meals offered as a part of maintenance or on a pay basis: Hospital policy regarding salaries will determine this. Also involved are the facilities provided for the cafeteria.

Meal census: Here, as for patients, a method of obtaining a meal census must be determined. Some of the methods used in hospitals are: Plate count, mechanical counter, the employee's signing or checking his or her name on a daily register, the employee's signing individual slips placed on the tables in the dining room, customer number cards, cash register (pay cafeteria) and meal tickets. The first two methods are dependent upon the employees' accuracy. The two methods in which the signing of the name is a factor may be successful or may be a bother and irritation to the employees. Customer cards are a unique idea, but the cash register or meal tickets probably are the most accurate methods yet devised.

Meals for physicians, private-duty nurses and visitors: The pay cafeteria automatically takes care of this decision. If a pay cafeteria is not provided, meal tickets are usually sold at the information desk or in some other convenient place.

Special meals for professional groups: It is customary in most hospitals for the dietary department to serve dinner to the medical staff of the hospital on the night of their regular monthly meeting. Other professional groups also may wish to have dinner meetings at the hospital. This is good public relations, but the extra load placed on the dietary department should be taken into consideration in planning.

INFANT FORMULA

The preparation of infant formula may be a responsibility of the nursing department or the dietary department. This responsibility usually is fixed by the location of the formula room. The

department in charge will need to develop procedures and techniques for this function and to decide upon forms for the keeping of adequate records.

Hospital policies for all employees: The following are not essentially dietary policies, but information in this regard is needed by each new dietary employee. When these policies are definitely decided upon, a booklet or a mimeographed sheet giving this information may prove helpful to new employees:

PERSONNEL POLICIES

1. Pay day—When does the hospital week begin and end, and where does the employee receive his pay?

2. Laundry—Are uniforms laundered free of charge, or what is the charge per uniform? Where are soiled uniforms deposited, and how are clean ones obtained?

3. Locker keys—How are they obtained, and where are they turned in on the last day of employment? Is a deposit required?

4. Illness—To whom is illness reported, and what provisions are made for the medical care of employees?

5. Sick leave—How many days are allowed each year?

6. Holidays—What holidays will be observed, and how much time off are employees allowed for each holiday? Must the time be taken on the holiday, or may it be taken at some other convenient time?

Dietary department regulations for employees: Within the department there will be recommendations such as the following:

1. Uniforms—What type is required? Will they be furnished by the hospital, or must the employees furnish their own? Are hair nets or caps required for food handlers?

2. Food handling regulations (based on state health department requirements).

3. Other rules necessary in the individual situation.

STAFFING THE DIET DEPARTMENT

Delegation of supervisory responsibilities: It is important that there be, at all times, someone in the dietary department who is capable of taking charge of the department in the dietitian's absence. In the small institution this may be the head cook.

Number of employees necessary: The number required will vary in hospitals of the same size because of differences in the type of food service, physical facilities and the efficiency of workers. Relief on days off must also be taken into consideration. The U. S. Public Health Service has made the following estimates in regard to the number of dietary employees required in hospitals of 100 beds or less.

Beds	25	30	40	50	60	75	80	90	100
Employees	4	5	6	7	8	10	10	11	12

The number actually employed in a selected group of Illinois hospitals is as follows:

Beds	Under 25	25-49	50-99
Employees	1-3	3-7	4-15

Classification, duties and responsibilities of employees: In setting up a personnel classification, it may be well to consider first the jobs to be done or the various activities of the department, such as food preparation, tray set-up and distribution, cafeteria service or personnel food service, food storage, cleaning, dishwashing and preparation of special diets. The time involved will be a major consideration and may be studied by using a chart showing the coverage necessary for the day.

From this information we can determine the classifications we need to set up as cooks, kitchen helpers or dishwashers. The activity then can be broken down into specific duties, and the number of employees required for each activity can be determined.

Hours of duty: It is well for the person in charge of the dietary department to be familiar with labor department regulations. Copies of these regulations may be obtained from state departments of labor. The question of the split shift or straight shift will have to be decided. One advantage of the straight shift is that employees are on the premises only during working hours. The trend is toward the straight shift and a 40-hour week.

Some of the points to be considered fall logically into the category of operating procedures rather than policies. The following are suggestions to assist with the development of these procedures.

OPERATING PROCEDURES

One of the most important duties of the dietitian is menu planning. Sufficient time and thought should be allotted to this function. Nutritional adequacy should be checked periodically, and it is advantageous to write menus in advance. The American Hospital Association's Master Menu service is a means of obtaining well planned menus "ready made." These menus should stimulate interest in greater variety and can be used for new ideas if the service is not used in its entirety.

In the small hospital the dietitian usually is responsible for the purchase of all food supplies. In the larger hospital staple supplies may be bought by the purchasing agent in accordance with the dietitian's specifications. The person planning the menus should make the decisions as to the quality and type of food desired. All sources of food supply should be investi-

Activity	6-7 A.M.	7-8 A.M.	8-9 A.M.	9-10 A.M.	10-11 A.M.	11 A.M. to noon
Food preparation						→
Tray set-up		→			→	
Tray distribution			→			→

gated — both local suppliers and wholesale houses serving the area. It is important to decide upon the type and quality best suited for the probable use of each item. Government grades should be used as a guide. A less expensive grade may be satisfactory for some uses. It is well to set up specifications so that fair comparisons of products can be made.[4] The objective in food purchasing should be to obtain the best quality for the specific use for the lowest cost per serving. All purchases should be checked on delivery. There is no value in definite specifications if the buyer is not certain that the product received is of the quality ordered.

FOOD STORAGE

Food storage is a most important consideration. A thermometer should be provided for each refrigerator so that temperatures may be checked daily. Recommended temperatures for the storage of the three general types of food are: Perishable—50° F. or below; raw meats—40° F. or below, and frozen foods—0° to 10° F.

Other points to be checked in regard to food storage are: (1) All perishable foods should be kept in the refrigerator. (2) Foods should not be crowded or stacked in the refrigerator. (3) Fresh produce should be checked before storage and over-ripe or decayed parts disposed of. Also, fresh produce should be used promptly to avoid spoilage. (4) Staple groceries and canned goods should be stored in a cool, dry room that is well ventilated. A temperature of 60° to 70° F. is recommended. (5) Windows should be screened, and walls and floors should be rat-proof. (6) Staples in cloth or paper bags should be cross-stacked on racks to provide for air circulation. (7) Cereals and cereal products purchased in bulk quantities should be stored in metal containers with tightly fitting lids.

Food products of uniform good quality and attractive appearance are appreciated. For example, a specific product, such as a baked pudding, should look and taste the same each time it is served, no matter if a relief cook has made it. Use of standardized recipes should help to produce these results.

The Dietetics Administration department is edited by Margaret Gillam, dietetics specialist.

The dietitian should be familiar with all state health department regulations regarding sanitation, and any question in this regard should be referred to this department for clarification. State regulations are generally based on the U. S. Public Health Service code[5] and include information on the construction of utensils and equipment, cleaning and bactericidal treatment of utensils and equipment, storage of utensils and equipment, disposal of wastes, refrigeration, cleanliness and health of employees and rodent and vermin control. Minimum dishwashing standards for hospitals are discussed in full in a recent HOSPITALS article by Margaret Gillam.[6]

Employee training usually will pay dividends in careful, dependable employees. Each employee should receive training in sanitary methods of food handling, safety measures and assigned duties. Up-to-date written records of the duties involved in each job are helpful not only to the employee but also to the supervisor and particularly the new supervisor. The new employee should be not only *told* about his duties but *shown*.

VALUE OF RECORDS

Records are valuable in that they make available information necessary for the efficient operation of the department. This information is of no value, however, unless it is used. The following are some of the records useful in dietary department operation: Food served (menus), satisfactory recipes (recipe file), food purchased, food received, supplies on hand (inventory), therapeutic diets served, cost of food served, equipment, number of meals served, infant formula prepared, employee records and forms for ordering diets and between-meal feedings. Food cost accounting is based on records kept. This information is valuable because it promotes good management, provides information for budget planning, provides a gauge for economical operation and promotes cost consciousness among dietary personnel.

Therapeutic diets are another responsibility of the dietary department. Although special diets must be adapted to the individual patient, the preparation and service of these diets is facilitated if the same basic pattern for the diets most commonly used is decided upon by all staff physicians. In some hospitals a committee of the medical staff is appointed to discuss these matters with the dietitian and make recommendations to the staff as a whole. A diet manual for each hospital is desirable.

CONCLUSION

Most of the difficulties that occur in hospital dietary departments may be due to one or more of the following:

1. A lack of understanding between the administrator and the dietitian or between the dietitian and the personnel of other departments.

2. Insufficient and inefficient personnel to carry on the basic functions of the department, with the result that the person in charge is too overworked to pay attention to important details and to initiate improvements.

3. A lack of clear-cut personnel policies and a lack of employee training.

4. Poor and inadequate physical facilities.

In a new hospital the fourth difficulty should not exist. If the other three points are recognized and every effort is made to see that they do not exist, there should be no reason for an inefficient dietary department.

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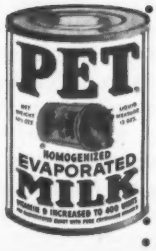

SERVING THE PROFESSIONAL MEN AND WOMEN WHO PROTECT THE NATION'S HEALTH

DIETETICS ADMINISTRATION COMMENT

Vegetable cooking tips

OVER A PERIOD of several years, the institution management department of Cornell University's College of Home Economics has been doing research on vegetable cookery. At the Association's recent dietetics institute in Buffalo, Kathleen Cutlar, assistant professor in this department, reported on some of the findings and results as follows:

1. Quantity vegetable cooking should be scheduled so that the vegetables are eaten within 30 minutes of cooking. In the experiment there was some loss of ascorbic acid during this holding period besides that lost during the cooking period. After 30 minutes the rate of loss was more rapid and in many cases the palatability and appearance deteriorated more rapidly. Frozen vegetables did not seem to lose ascorbic acid as rapidly as fresh vegetables.

2. The appearance of green vegetables was superior when cooked in steam-jacketed kettles. Large amounts may be cooked at one time in this type of equipment because of the rapidity with which the water comes back to a boil. When green vegetables were cooked in the steamer the color was acceptable but this color deteriorated on holding for even a short period after cooking.

3. When green vegetables were cooked in a container on top of a stove the ascorbic acid losses were less when small quantities (not more than five pounds) were cooked at one time.

4. In experimenting with potatoes, one group of research workers found that the best method of cookery, from the standpoint of the retention of ascorbic acid and other vitamins, was steaming. There were no severe losses of ascorbic acid during the soaking period before cooking. Holding the potatoes after cooking, however, resulted in losses of 40 to 45 per cent. Higher losses resulted when the potatoes were mashed than when they were steamed and left whole. Regardless of the method and equipment used in holding vegetables before service, that holding period should be kept to a minimum.

5. When cabbage and broccoli were held in the cooking water until served they deteriorated rapidly in palatability. When frozen lima beans and cauliflower were held in the cooking water prior to serving they rated high impalatability.

6. Other methods of holding cooked vegetables were:

(a) Drained and held in the Bain Marie.

(b) Drained and held in a food warmer at about 138° to 140°F.

(c) Drained and held in a covered container on the counter.

(d) Drained and held covered in a steam-jacketed kettle.

The ascorbic acid losses from the vegetables studied did not vary greatly in these methods of holding, Miss Cutlar reported. There was some difference in palatability, depending on the vegetable. In all cases, ascorbic acid losses began to increase substantially after 30 minutes.—M.G.

Master Menus for August

THE AUGUST SERIES of the American Hospital Association's Master Menu is printed on this and the following pages.

These menus reduce to a minimum the number of diets, simplify planning, decrease costs and conserve food preparation time. The general diet forms the basis of the seven most commonly used special hospital diets. All except the liquid diets have been planned to include the nine food essentials and servings required for nutritional adequacy.

Consideration is also given flavor, variety, attractiveness and general acceptance by patients. Color is a factor, and color combinations must harmonize. Foods in each meal are planned in a variety of forms, not all flat, high or round but a pleasing combination of shapes. Consistency, too, is important, and here the accent is on variety. If some foods are served in a soft form, a crisp food is included in the meal. Flavor gives zest to a meal, and this aspect receives consideration in the planning of the menus.

To use these menus, (1) read the selections for the general (boldface type) and seven special diets, (2) type the day-by-day menu suggestions on transfer slips, spaced and numbered to correspond with the Master Menu wall charts, and (3) attach the completed slips on the spaces and corresponding numbers on the breakfast, dinner and supper wall charts.

Additional blocks of perforated transfer slips and Master Menu kits may be purchased from the Association, 18 E. Division Street, Chicago 10.

August 1

1. **Fresh Plums**
2. Blended Juice
3. **Crisp Rice Cereal or Scotch Bran Brose**
4. **Soft Cooked Egg**
5. Bacon
6. **Sweet Rolls**

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7. **Jellied Broth**
8. **Melba Toast**
9. **Turkey a la King on Hot Biscuits**
10. Roast Lamb
11. ———
12. Whipped Potatoes
13. **Green Peas**
14. Acorn Squash Rings
15. **Peach and Raisin Salad**
16. **Whipped Cream Mayonnaise**
17. **Watermelon Wedges**
18. Raspberry Bavarian
19. Raspberry Gelatin Whip
20. Watermelon Cubes
21. Golden Punch

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22. **Cream of Corn Soup**
23. **Cheese Popcorn or Crackers**
24. **Beef Tenderloin Tips on Noodles**
25. Chopped Beef Steak
26. Chopped Beef Steak
27. Noodles
28. **Wax Beans**
29. **Tomato Halves with Cress**
30. **Mayonnaise**
31. **Sugared Fresh Berries—Rich Cookies**
32. Canned Fruit Cup
33. Soft Custard
34. Fresh Berries
35. Orange Juice
36. **Bread**

August 2

1. **Cantaloupe**
2. Orange Juice
3. **Rolled Wheat or Corn Flakes**
4. **Poached Egg**
5. Grilled Ham
6. **Blueberry Muffins**

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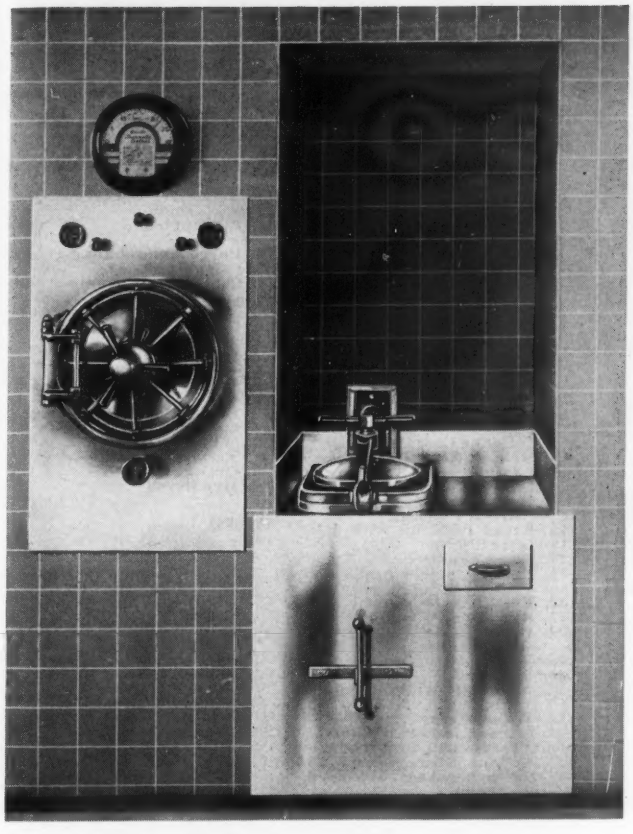
7. **Beef Broth**
8. **Toasted Crusts**
9. **Veal Birds with Savory Stuffing**
10. Broiled Veal Steak
11. **Parslied Potatoes**
12. Parslied Potatoes
13. **Baked Sliced Eggplant**
14. Fresh Spinach
15. **Cabbage and Toasted Almond Salad**
16. **Cream-Vinegar Dressing**

THE PATIENT COMES FIRST

In Any Recommendation We Make



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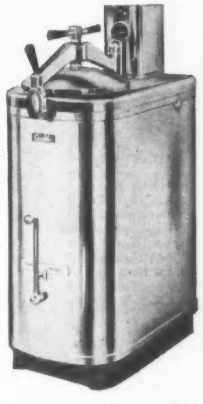


Instrument Washer-Sterilizer, Cabinet Model

Castle LIGHTS AND STERILIZERS

17. **Steamed Cherry Pudding, Cherry Sauce**
18. Vanilla Blanc Mange—Cherry Sauce
19. Vanilla Blanc Mange
20. Bing Cherries
21. Peach Lemonade

22. **Turkey and Rice Soup**
23. **Saltines**
24. **Club Sandwich**
25. Minced Lamb—Carrots
26. Cold Roast Lamb—Carrots
27. Parslied Lattice Potatoes
28. ———
29. **Celery Hearts**
30. ———
31. **Fresh Pear—Cheese and Crackers**
32. Pear in Lime Gelatin
33. Lime Gelatin
34. Fresh Pear
35. Tomato Juice
36. ———

August 3

1. **Ribier Grapes**
2. Grapefruit Juice
3. **Puffed Rice or Granular Wheat Cereal**
4. **Scrambled Egg**
5. Link Sausage
6. **Honey Buns**

7. **Mushroom Bouillon**
8. **Celery Crackers**
9. **Broiled Sirloin Steak, Herb Butter**
10. Broiled Sirloin Steak
11. **French Fried Potatoes**
12. Potato Balls
13. **Cauliflower Polonaise**
14. Sliced Beets
15. **Hearts of Lettuce Salad**
16. **Blue Cheese Dressing**
17. **Orange Sherbet**
18. Orange Sherbet
19. Orange Sherbet
20. Honeydew Melon
21. Limeade

22. **Cream of Spinach Soup**
23. **Croutons**
24. **Mixed Grill—Chicken Livers, Bacon, Grilled Tomato Half**
25. Broiled Chicken Livers—Crisp Bacon—Asparagus
26. Scrambled Egg—Chicken Livers—Grilled Tomato
27. Baked Potatoes
28. ———
29. **Vegetable Salad Relish**
30. **Celery Seed Dressing**
31. **Sliced Fresh Peaches**
32. Stewed Fresh Peaches
33. Baked Custard
34. Sliced Fresh Peaches
35. Blended Juice
36. **Corn Sticks**

August 4

1. **Bananas**
2. Prune Juice
3. **Hominy or Shredded Wheat**
4. **Poached Egg**
5. Bacon
6. **Toast**

7. **Citrus Fruit Juice**
8. ———
9. **Baked Halibut Steak**
10. Broiled Halibut Steak
11. **Whole Potatoes with Cream Pimiento and Parsley Sauce**
12. Steamed Potatoes
13. **Fresh Lima Beans**
14. Diced Summer Squash
15. **Cucumber Sticks—Radishes**
16. ———
17. **Chocolate Cup Cakes**
18. Chocolate Pudding, Whipped Cream
19. Chocolate Rennet-Custard
20. Fresh Pineapple
21. Cream of Potato Soup

22. **Cream of Mushroom Soup**
23. **Saltines**
24. **Crabmeat Salad—Baked Potatoes**
25. Baked Rice and Cheese—Green Beans
26. Broiled Salmon—Green Beans
27. Steamed Rice
28. ———
29. **Asparagus Salad**
30. **French Dressing**
31. **Blueberry Tarts**
32. Fresh Applesauce
33. Cherry Gelatin Cubes
34. Fresh Blueberries
35. Apricot Nectar
36. **Hot Biscuits**

August 5

1. **Orange Juice**
2. Orange Juice
3. **Wheat Flakes or Oatmeal**
4. **Soft Cooked Egg**
5. Bacon
6. **Raisin Toast**

7. **Consomme**
8. **Crisp Crackers**
9. **Baked Ham Loaf**
10. Roast Beef
11. **Mashed Sweet Potatoes**
12. Riced Potatoes
13. **Kale**
14. Carrot Rings
15. **Pear and Cottage Cheese Salad**
16. **French Dressing**
17. **Raspberry Ice Cream Pie**
18. Jelly Roll
19. Whipped Lime Gelatin
20. Seedless Grapes
21. Pineapple Juice
22. **Tomato Celery Soup**
23. **Melba Toast**

24. **Broiled Lamb Cutlet—Scalloped Potatoes**
25. Broiled Lamb Cutlet
26. Broiled Lamb Cutlet
27. New Potatoes
28. **Green Peas**
29. **Mexican Slaw**
30. **Oil-Vinegar Dressing**
31. **Fruit Plate—Apricot, Plum, Grapes**
32. Canned Peeled Apricots
33. Soft Custard
34. Fresh Plums
35. Mixed Fruit Juice
36. **Frosted Raisin Rolls**

August 6

1. **Sliced Fresh Peaches**
2. Grapefruit Juice
3. **Farina or Wheat and Barley Kernels**
4. **Scrambled Egg**
5. Country Sausage
6. **Hot Biscuits**

7. **Vegetable Juice Cocktail**
8. ———
9. **Broiled Chicken**
10. Roast Chicken
11. **New Potatoes**
12. New Potatoes
13. **Corn on Cob**
14. Frenched Green Beans
15. **Tossed Green Salad**
16. **Italian Dressing**
17. **Cherry Ice Cream**
18. Cherry Ice Cream
19. Lemon Sherbet
20. Fresh Fruit Cup
21. Cream of Carrot Soup

22. **Potage Longchamps**
23. **Croutons**
24. **Rice Croquettes with Jelly—Crisp Bacon**
25. Crisp Bacon
26. Cold Roast Beef
27. Baked Potatoes
28. **Spinach with Lemon**
29. **Layered Orange and Cheese Salad**
30. **Cream Mayonnaise**
31. **Honeydew Melon**
32. Prune Whip
33. Raspberry Rennet-Custard
34. Honeydew Melon
35. Apple Juice
36. **Bran Muffins**

August 7

1. **Tomato Juice**
2. Tomato Juice
3. **Crisp Rice Cereal or Granular Wheat Cereal**
4. **Poached Egg**
5. Canadian Bacon
6. **Toast**

7. **Jellied Broth**
8. **Saltines**
9. **Rolled Stuffed Flank Steak—Gravy**
10. Broiled Steak
11. **Pimiento Potato Souffle**
12. Whipped Potatoes
13. **Baked Butternut Squash**
14. Asparagus Tips
15. **Cucumber and Onion Slices in Tart Vinegar**
16. ———
17. **Apple Cobbler, Brown Sugar Sauce**
18. Butterscotch Pudding, Whipped Cream
19. Orange Gelatin
20. Fresh Apricots
21. Grape Juice

22. **Cream of Chicken Soup**
23. **Crisp Crackers**
24. **Salad Plate—Jellied Cottage Cheese Mold, Lettuce Cups with Melon Balls, Sliced Bananas, Bing Cherries, Apricot Halves**
25. Broiled Liver—Beet Greens
26. Broiled Liver—Beet Greens
27. Potato Balls
28. ———
29. **Celery Hearts**
30. ———
31. **Date Sandwich Cake, Whipped Cream**
32. Stewed Bing Cherries
33. Baked Custard
34. Bing Cherry, Orange Cup
35. Grapefruit Juice
36. **Broiled Nippy Cheese on Split Biscuits**

August 8

1. **Orange Juice**
2. Orange Juice
3. **Rolled Wheat or Crisp Oat Cereal**
4. **Scrambled Egg**
5. Bacon
6. **Toast**

7. **Chicken Bouillon**
8. **Celery Crackers**
9. **Roast Leg of Veal**
10. Roast Leg of Veal
11. **Potatoes au Gratin**
12. Parslied Lattice Potatoes
13. **Sliced Zucchini**
14. Julienne Carrots
15. **Molded Bing Cherry Cress Salad**
16. **Cream Mayonnaise**
17. **Warm Orange Marmalade Bread Pudding**
18. Bread Pudding with Jelly
19. Lime Sherbet
20. Fresh Plums
21. Cranberry and Apple Juice

22. **French Onion Soup**
23. **Rye Cheese Croutons**
24. **Italian Spaghetti with Meat Balls**
25. Beef Pattie
26. Beef Pattie
27. Spaghetti with Tomato Puree
28. **Whole Green Beans**
29. **Mixed Green Salad Bowl**
30. **Vinegar-Oil Dressing**
31. **Sponge Cake, Sliced Peaches Atop, Whipped Cream**
32. Stewed Peaches—Sponge Cake
33. Apricot Nectar Mold
34. Sliced Fresh Peaches
35. Pineapple Juice
36. **French Bread**

August 9

1. **Honey Ball Melon**
2. Blended Juice
3. **Puffed Wheat or Oatmeal**
4. **Soft Cooked Egg**
5. Bacon
6. **Crumb Buns**

7. **Consomme**
8. **Toasted Crusts**
9. **Baked Ham—Grape Sauce**
10. Roast Rib of Beef
11. **Mashed Potatoes**
12. Baked Potatoes
13. **Green Cabbage**
14. Mashed Squash
15. **Pineapple Salad on Endive**
16. **Chutney Dressing**
17. **Fluffy Lemon Custard**
18. Fluffy Lemon Custard
19. Cherry Gelatin Cubes
20. Orange and Blueberry Cup
21. Apple Juice

22. **Tomato Juice**
23. ———
24. **Creamed Chicken and Mushrooms on Rice**
25. Creamed Chicken
26. Sliced Chicken
27. Steamed Rice
28. **Green Peas**
29. **Asparagus Salad**
30. **Piquante French Dressing**
31. **Honeyed Baked Pear**
32. Honeyed Baked Peeled Pear
33. Fluffy Lemon Custard
34. French Pear
35. Beef Bouillon
36. **Bread**

August 10

1. **Grapefruit Juice**
2. Grapefruit Juice
3. **Rolled Wheat or Crisp Rice Cereal**
4. **Poached Egg**
5. Link Sausage
6. **Corn Muffins**

7. **Beef Bouillon**
8. **Melba Toast**
9. **Country Fried Liver—Bacon**
10. Broiled Liver
11. **New Potatoes, Cream Sauce**
12. New Potatoes
13. **Stewed Tomatoes and Okra**
14. Baked Eggplant Slice
15. **Cantaloupe Ring Fruit Salad**
16. **Fruit Dressing**
17. **Butter Pecan Ice Cream**
18. Raspberry Sherbet
19. Raspberry Sherbet
20. Watermelon
21. Pineappleade

22. **Puree Mongol Soup**
23. **Crisp Crackers**
24. **Cold Cuts—Cucumber Sauce—Potato Salad**
25. Minced Beef—Asparagus
26. Cold Roast Beef—Asparagus
27. Baked Sweet Potatoes
28. ———
29. **Carrot Curls and Radishes**
30. ———
31. **Baked Peach Dumpling**
32. Canned Fruit Compote
33. Whipped Lime Gelatin
34. Fresh Plum Cup
35. Orange Juice
36. **Rye Bread**

August 11

1. **Cantaloupe**
2. Blended Juice
3. **Bran Flakes or Farina**
4. **Scrambled Egg**
5. Bacon
6. **Raisin Toast**

7. **Celery Broth**
8. **Saltines**
9. **Salmon Loaf**
10. Broiled Haddock
11. **Scalloped Potatoes**
12. Whipped Potatoes
13. **Peas and Mushrooms**
14. Fresh Spinach
15. **Sliced Egg on Romaine Salad**
16. **Anchovy French Dressing**
17. **Deep-Dish Cherry Pie**
18. Boston Cream Pie
19. Banana Whip
20. Bing Cherries
21. Apricot Nectar

22. **Tomato Bouillon**
23. **Cheese Crackers**
24. **French Fried Shrimp, Tartar Sauce—New Potatoes**
25. Creamed Tuna
26. Cold Tuna on Lettuce
27. Baked Stuffed Potatoes
28. **Whole Green Beans**
29. **Tossed Salad**
30. **Vinegar-Oil Dressing**
31. **Snow Pudding, Sugared Diced Oranges**
32. Snow Pudding, Sugared Diced Oranges
33. Snow Pudding—Custard Sauce
34. Diced Orange Cup
35. Grapefruit Juice
36. **Cloverleaf Rolls**

August 12

1. **Sliced Banana in Orange Juice**
2. Orange Juice
3. **Granular Wheat Cereal or Corn Flakes**
4. **Poached Egg**
5. Grilled Ham
6. **Coffee Cake**

7. **Mushroom Bouillon**
8. **Toasted Crackers**
9. **Roast Beef au Jus**

Around the Wards with Kellogg's

Patient Barbara:

Ummmm! Just like home! My favorite breakfast! (Kellogg's Cereals *are* a tasty treat. Hospital records show that they're favorites with patients the country over.)

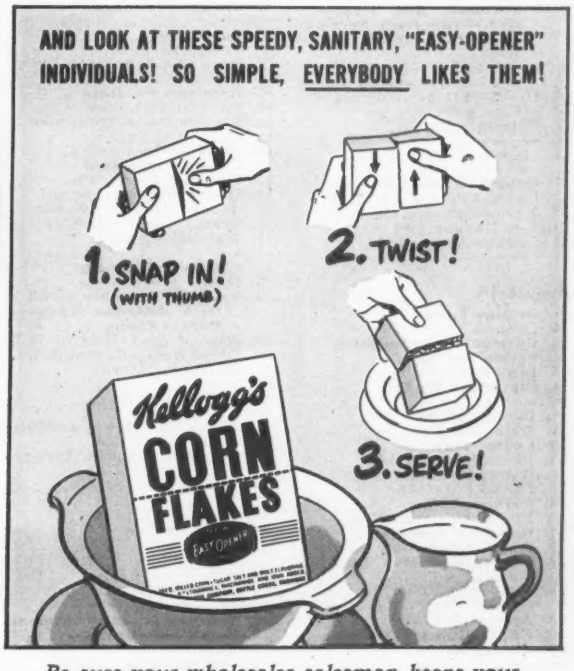
Nurse Jones:

Thank goodness for Kellogg's Individuals! They save me so much time with breakfast.. There's a choice for everyone in the Kellogg line—and they're a cinch to serve.

Dietitian Daniels:

Breakfast planning is so much easier with Kellogg's big assortment of flaked, shredded and popped cereals. All Kellogg cereals either are made from the whole grain or are restored to whole grain levels of thiamine, niacin and iron!

MORE PEOPLE PREFER Kellogg's



Be sure your wholesaler salesman keeps your assortment of Kellogg's complete at all times.

KELLOGG'S CORN FLAKES • RICE KRISPIES • PEP • KELLOGG'S 40% BRAN FLAKES • CORN-SOYA KRUMBLES • KELLOGG'S SHREDDED WHEAT • KELLOGG'S RAISIN BRAN FLAKES • ALL-BRAN

10. Roast Beef
11. **Mashed Potatoes**
12. Parslied Lattice Potatoes
13. **Broiled Tomatoes**
14. Baked Acorn Squash
15. **Mixed Greens**
16. **Blue Cheese French Dressing**
17. **Fresh Pear and Grapes**
18. Banana Chocolate Pudding
19. Assorted Gelatin Cubes
20. Fresh Pear and Grape Cup
21. Limeade

22. **Corn Chowder**
23. **Saltines**
24. **Sausage Stuffed Baked Acorn Squash**
25. Broiled Veal Chop
26. Broiled Veal Chop
27. Noodles
28. **Sliced Beets**
29. **Cabbage and Apple Slaw**
30. **Cream Mayonnaise**
31. **Raspberry Whipped Cream Sponge Cake Roll**
32. Peach Whip
33. Vanilla Ice Cream
34. Melon Ball Cup
35. Blended Juice
36. **Oatmeal Rolls**

August 13

1. **Tomato Juice**
2. Tomato Juice
3. **Shredded Wheat or Hominy**
4. **Soft Cooked Egg**
5. Bacon
6. **Toast**

7. **Consomme a la Royal**
8. **Saltines**
9. **Roast Turkey with Stuffing —Jelly**
10. Roast Turkey
11. **Mashed Potatoes**
12. Whipped Potatoes
13. **Sliced Zucchini**
14. Quartered Carrots
15. **Raw Turnip and Carrot Sticks**
16. ———
17. **Fresh Peach Sundae**
18. Vanilla Ice Cream
19. Lemon Sherbet
20. Sliced Fresh Peaches
21. Cranberry and Pineapple Juice

22. **Cream of Mushroom Soup**
23. **Melba Toast**
24. **Fruit Salad—Sliced Pineapple, Pear with Cheese, Coconut, Red Raspberries, Grapefruit Sections —Banana Bread Sandwich**
25. Lamb Pattie—Broiled Pear with Jelly—Asparagus
26. Lamb Pattie—Broccoli—Celery Hearts
27. Potato Balls
28. ———
29. ———
30. ———
31. **Baked Caramel Custard**
32. Canned Peeled Apricots
33. Baked Caramel Custard
34. Red Raspberries
35. Orange Juice
36. ———

August 14

1. **Orange Juice**
2. Orange Juice
3. **Oatmeal or Puffed Rice**
4. **Scrambled Egg**
5. Link Sausage
6. **Cinnamon Muffins**

7. **Beef Bouillon**
8. **Melba Toast**
9. **Swiss Steak**
10. Roast Leg of Veal
11. **Baked Potatoes**
12. Baked Potatoes
13. **Corn on Cob**
14. Frenched Green Beans
15. **Hearts of Lettuce**
16. **Russian Dressing**
17. **Crackers, Cheese, Guava Jelly**
18. Crackers, Cheese, Guava Jelly
19. Apricot Whip
20. Fresh Plums
21. Cherry Nectar

22. **Cream of Turkey Soup**
23. **Crisp Crackers**
24. **Savory Spanish Rice, Crisp Bacon**
25. Crisp Bacon
26. Broiled Steak
27. Rice with Tomato Puree
28. **Spinach, Egg Garnish**
29. **Iced Relishes**
30. ———
31. **Apple Souffle with Ice Cream**
32. Fresh Applesauce
33. Vanilla Ice Cream
34. Ribfer Grapes
35. Mixed Fruit Juice
36. **Swedish Rye Bread**

August 15

1. **Sliced Bananas**
2. Blended Juice
3. **Corn Flakes or Granular Wheat Cereal**
4. **Poached Egg**
5. Bacon
6. **Toast**

7. **Tomato Juice**
8. ———
9. **Roast Pork, Applesauce**
10. Broiled Lamb Chop
11. **Hominy**
12. Riced Potatoes
13. **Turnip Greens**
14. Diced Beets
15. **Cabbage, Carrot and Nut Salad**
16. **Tarragon Dressing**
17. **Baked Fudge Pudding**
18. Jellied Canned Fruit
19. Orange Sherbet
20. Fresh Pear
21. Cream of Corn Soup

22. **Vegetable Soup**
23. **Saltines**
24. **Creamed Dried Beef and Mushrooms on Chinese Noodles**
25. Broiled Sweetbreads
26. Broiled Sweetbreads
27. Duchess Potatoes
28. **Green Peas**
29. **Fresh Peach Cup Salad**
30. **French Dressing**
31. **Honeydew Melon, Lime Wedge**
32. Prune Whip
33. Floating Island
34. Honeydew Melon
35. Pineapple Juice
36. **Bread**

August 16

1. **Grapefruit Juice**
2. Grapefruit Juice
3. **Farina or Corn Soya Shreds**
4. **Scrambled Egg**
5. Country Sausage
6. **Toast**

7. **Consomme**
8. **Crisp Crackers**
9. **Beef Chuck Roast—Gravy**
10. Broiled Liver
11. **Browned Potatoes**
12. Paprika Potatoes
13. **Stewed Fresh Tomatoes**
14. Butternut Squash
15. **Head Lettuce Salad**
16. **Chutney Dressing**
17. **Coconut Cream Pie**
18. Orange Cream Custard
19. Assorted Gelatin Cubes
20. Orange and Grape Cup
21. Apricot Nectar

22. **Cream of Pea Soup**
23. **Herb Croutons**
24. **Tossed Vegetable Salad with Julienne Meat—Potato Chips**
25. Minced Beef—Carrot Balls
26. Diced Beef—Carrot Balls
27. Baked Potatoes
28. ———
29. **Stuffed Celery**
30. ———
31. **Fresh Blackberries—Thin Cream**
32. Sliced Banana in Orange Juice
33. Cream Custard
34. Fresh Blackberries
35. Blended Juice
36. **Corn Muffins**

August 17

1. **Orange Juice**
2. Orange Juice
3. **Wheat Flakes or Oatmeal**
4. **Soft Cooked Egg**
5. Bacon
6. **Hot Biscuits**

7. **Beef Bouillon**
8. **Melba Toast**
9. **Turkey Cutlet—Parsley Cream Sauce**
10. Hot Sliced Turkey
11. **Parslied Potatoes**
12. Parslied Potatoes
13. **Corn on Cob**
14. Asparagus Tips
15. **Celery and Olives**
16. **Cream Mayonnaise**
17. **Raspberry Sherbet**
18. Raspberry Sherbet
19. Raspberry Sherbet
20. Fresh Fruit Cup
21. Pineapple Juice

22. **Cream of Spinach Soup**
23. **Croutons**
24. **Grilled Ham—Mashed Sweet Potatoes**
25. Roast Lamb—Spinach
26. Roast Lamb—Spinach
27. Mashed Sweet Potatoes
28. ———
29. **Cabbage and Green Pepper Slaw**
30. **Sour Cream Dressing**
31. **Watermelon**
32. Stewed Peach and Bing Cherry Compote
33. Cherry Gelatin Cubes, Custard Sauce
34. Watermelon
35. Grapefruit Juice
36. **Blueberry Muffins**

August 18

1. **Fresh Bing Cherries**
2. Tomato Juice
3. **Granular Wheat Cereal or Puffed Rice**
4. **Baked Egg** (Omit on General)
5. Link Sausage
6. **French Toast—Syrup**

7. **Essence of Vegetable Soup**
8. **Whole Wheat Wafers**
9. **Broiled Whitefish—Lemon Butter**
10. Broiled Whitefish—Lemon Wedge
11. **Potatoes au Gratin**
12. Cubed Potatoes
13. **Sliced Beets**
14. Tender Swiss Chard Leaves
15. **Jellied Raw Vegetable Salad**
16. **Mayonnaise**
17. **Orange Chiffon Pie**
18. Orange Chiffon Pudding
19. Grape Juice Sponge
20. Sliced Fresh Peaches
21. Lemonade

22. **Old-fashioned Potato Soup**
23. **Crisp Crackers**
24. **Olive Creole Omelet**
25. Cheese Omelet
26. Omelet
27. Stuffed Baked Potatoes
28. **Frenched Green Beans**
29. **Cottage Cheese and Chives on Lettuce**
30. ———
31. **Iced Lemonade—Chocolate Cookies**
32. Canned Pears
33. Baked Custard
34. Pear and Red Plum Cup
35. Orange Juice
36. **Hard Rolls**

August 19

1. **Cantaloupe**
2. Prune Juice with Lemon
3. **Wheat and Barley Kernels or Farina**
4. **Scrambled Egg**
5. Bacon
6. **Toast**

7. **Consomme**
8. **Saltines**
9. **Brisket of Corned Beef**
10. Broiled Beef Tenderloin
11. **Boiled Potatoes**
12. Whipped Potatoes
13. **Green Cabbage Wedge**
14. Sliced Carrots
15. **Banana Nut Salad**
16. **Cream Mayonnaise**
17. **Rice Pudding, Strawberry Hard Sauce**
18. Rice Pudding
19. Lemon Rennet-Custard
20. Orange and Banana Cup
21. Apple Juice

22. **Chicken Gumbo Soup**
23. **Crisp Crackers**
24. **Jellied Veal Loaf—Stuffed Egg Half—Cress**
25. Broiled Veal Pattie
26. Broiled Veal Pattie
27. Fluffy Rice
28. **Green Peas**
29. **Chilled Tomato Halves**
30. **Mayonnaise**
31. **Fresh Blueberries—Thin Cream**
32. Orange Section and Banana Cup
33. Vanilla Ice Cream
34. Fresh Blueberries
35. Apricot Nectar
36. **Orange and Raisin Rolls**

August 20

1. **Orange Halves**
2. Grapefruit Juice
3. **Rolled Wheat or Crisp Rice Cereal**
4. **Poached Egg**
5. Canadian Bacon
6. **Raisin Toast**

7. **Julienne Vegetable Bouillon**
8. **Crisp Crackers**
9. **Chicken Fricassee**
10. Roast Chicken
11. **Paprika New Potatoes**
12. Paprika New Potatoes
13. **Cauliflower**
14. Acorn Squash
15. **Assorted Relishes**
16. ———
17. **Maple Nut Ice Cream**
18. Lime Sherbet
19. Lime Sherbet
20. Watermelon Cubes
21. Grapeade

22. **Philadelphia Pepper Pot Soup**
23. **Saltines**
24. **Macaroni Salad—Sliced Corned Beef**
25. Broiled Lamb Chop—Lattice Beets
26. Broiled Lamb Chop—Stewed Celery
27. Whipped Potatoes
28. ———
29. **Chilled Lattice Beets**
30. ———
31. **Stewed Italian Prunes**
32. Fresh Applesauce
33. Chocolate Blanc Mange
34. Seedless Grapes
35. Blended Juice
36. **Hot Biscuits—Honey**

August 21

1. **Tomato Juice**
2. Tomato Juice
3. **Wheat Shreds or Hominy**
4. **Soft Cooked Egg**
5. Bacon
6. **Toast**

7. **Consomme**
8. **Melba Toast**
9. **Broiled Ham Slice**
10. Roast Beef
11. **Southern Corn Pudding**
12. Riced Potatoes
13. **Frenched Green Beans**
14. Mashed Parsnips
15. **Golden Glow Salad**
16. **Cream Mayonnaise**
17. **Blueberry Deep-Dish Pie**
18. Jellied Orange Sections
19. Orange Gelatin
20. Bing Cherries
21. Grapefruit Juice

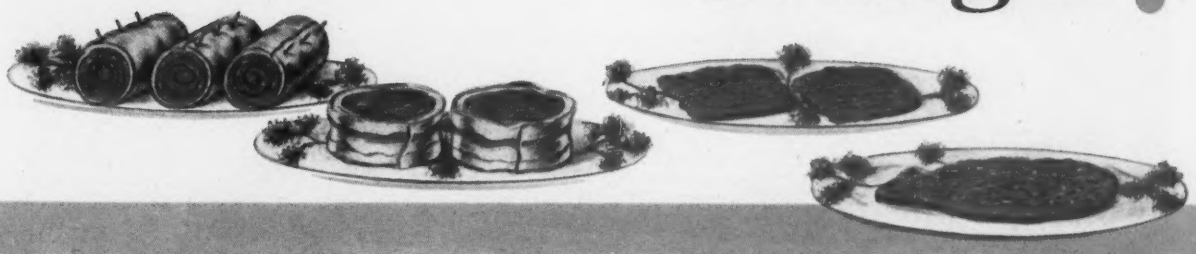
22. **Cream of Celery Soup**
23. **Toasted Crusts**
24. **Stuffed Green Pepper, Melted Cheese Topping**
25. Creamed Sweetbreads
26. Broiled Sweetbreads
27. Parslied Potatoes
28. **Julienne Carrots**
29. **Honeydew and Melon Ball Salad**
30. **French Dressing**
31. **Chocolate Pudding, Whipped Cream and Slivered Chocolate**
32. Cherry Sponge
33. Cherry Sponge
34. Fresh Pear
35. Orange Juice
36. **Bread**

August 22

1. **Grapefruit Juice**
2. Grapefruit Juice
3. **Oatmeal or Puffed Wheat**
4. **Scrambled Egg**
5. Bacon
6. **Frosted Raisin Rolls**

7. **Jellied Broth, Lemon Slice**
8. **Saltines**
9. **Deep-Dish Veal and Vegetable Pie, Flaky Crust**

Sheer Menu Magic!



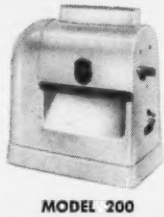
Add zestful meat specialties . . . control your costs . . . with a

HOBART STEAKMAKER® TENDERIZER

Toppers for taste and stoppers for high costs, *Steakmaker* delivers value by the hatful. Vitalize your menus with *minute steaks*, beef roulades, steak sabiouse, veal birds, etc.—all made by *Steakmaker* Tenderizers from end cuts, trimmings and odd pieces. Leading chefs, stewards and dieticians agree that *Steakmaker* specialties can't be equalled for popular appeal. Nor for food-budget mileage.

Steakmaker literally knits as it tenderizes. **Exclusive Knit-Knife, Draw-Cut Action combines tenderized small pieces, with or without garnishing, into tempting, nourishing, low-cost specialties—each a solid, complete serving. Like all Hobart products, *it is clean in design and clean in performance*, built to serve for years.**

Your own local Hobart representative can demonstrate the original Hobart-Federal *Steakmaker* Tenderizer right now. He's at your service with the greatest line of food and kitchen machines ever made—each one made in a variety of sizes to meet your needs most economically. And it never calls for any miracle at all to get quick, on-the-spot Hobart service. Just pick up that phone today—we're at your service.



MODEL 200

For complete information on the entire Hobart line see your Hobart representative, or write Dept. 2, Troy.

MODEL 400

Hobart TRADE MARK OF QUALITY

Hobart *Food Machines*

THE HOBART MANUFACTURING COMPANY • TROY, OHIO

The World's Largest Manufacturer of Food and Kitchen Machines

The magnificent Kaiser-Frazer Willow Run plant.
Its beautiful plant dining rooms and cafeteria are completely equipped with colorful, durable Jade-ite Fire-King Restaurant Ware.

JADE-ITE FIRE-KING* has a

the big Kaiser-Frazer dining rooms

Anchorglass FOREST GREEN
Rich, new, and distinctive Anchorglass Forest Green, attractive and colorful, is ideal for use in either color harmony or contrast settings ...includes every item for modern, practical table settings.

Anchorglass STEMWARE
A complete line of sparkling crystal stemware with matching salad and sherbet plates offering you a full range of sizes from the 9 oz. goblet to the 3½ oz. cocktail...all at a surprisingly low cost.

Anchorglass JADE-ITE FIRE-KING RESTAURANT WARE

Cut your dinnerware costs in half with Jade-ite Fire-King. *Heat-proof*...will not crack or craze from hot foods. *Stain-proof*...smooth, hard surface will not discolor. *Rugged*...made of durable Fire-King Ovenglass. *Sanitary*...non-absorbent, easy to clean and keep clean. *Colorful*...makes food look better. Available in a complete service... ideal for restaurants, hotels, cafeterias, lunchrooms, institutions, fountains and coffee shops.

star role in the show place of at Willow Run!

Mr. R. E. Heysell, Manager of the beautiful and efficient dining rooms at Willow Run says, "Everyone from office girl to top executive admires your dishes... most sanitary service we have ever used... easy to keep clean... minimum breakage... we have cut our dinnerware costs in half."

You, too, can assure a more appetizing background for the food you serve when you serve it on Jade-ite Fire-King Restaurant Ware.

And you can serve piping hot dishes without fear of breakage, cracking or crazing. So switch to Jade-ite Fire-King Restaurant Ware. Gain all these advantages... *and* cut your dinnerware costs in half.

Your jobber will be glad to show you the complete line of Jade-ite Fire-King Restaurant Ware. And at the same time, may we suggest you ask him to show you the Anchorglass Ruby, Forest Green and Crystal tumblers, goblets, sherbets and other essential items required for efficient, economical mass feeding purposes.

Anchor Hocking Glass Corporation Lancaster, Ohio

"The most famous name in glass!"

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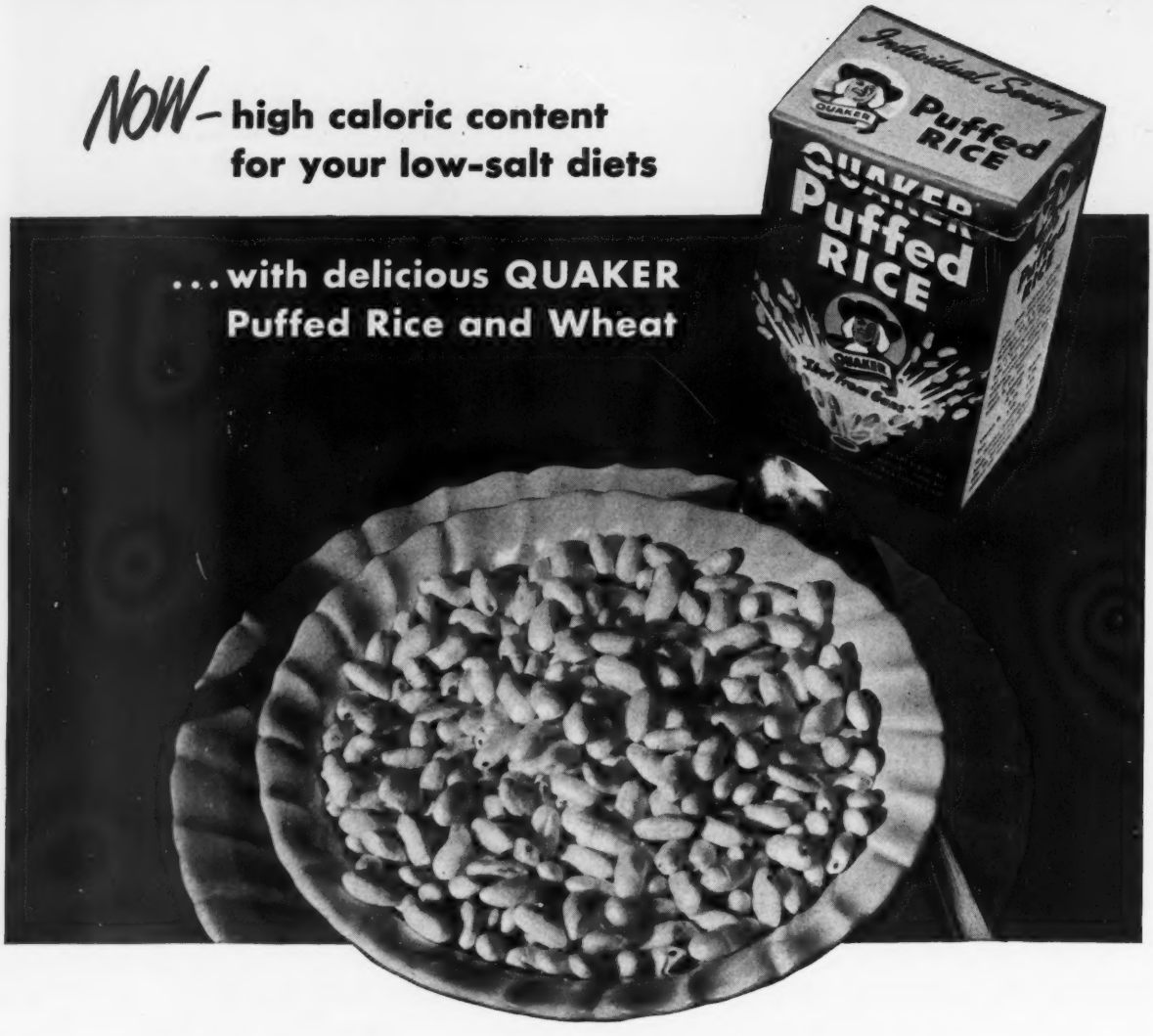
NOW— **high caloric content for your low-salt diets**



...with delicious QUAKER Puffed Rice and Wheat

Perplexed? Looking for tempting, *nourishing* foods that will satisfy the most exacting low-salt diets?

Then consider Quaker Puffed Rice and Wheat... hearty cereals that combine low sodium intake with high vitamin and mineral supply. *No sodium-containing salt has been added. Whole grain levels of the protective nutrients*—thiamin, niacin and iron—*have been restored.*

Alternate servings of these two tasty cereals give your hypertensive patients an appetizing change of pace. For Quaker Puffed Rice and Puffed Wheat are quite unlike each other in flavor.

Serve Quaker INDIVIDUAL Puffed Rice and Wheat—the *delicious* way to insure needed calories in low-salt diets.

QUAKER INDIVIDUAL PUFFED RICE & PUFFED WHEAT

The Quaker Oats Company, Chicago 4, Illinois

10. Roast Veal Loin
11. ———
12. Parslied Potatoes
13. **Broccoli**
14. Sliced Beets
15. **Tomato Cress Salad**
16. **French Dressing**
17. **Cantaloupe a la Mode**
18. Vanilla Ice Cream
19. Apricot Sherbet
20. Cantaloupe Slices
21. Cranberry and Apple Juice

22. **Mulligatawny Soup**
23. **Crisp Crackers**
24. **Potato Salad—Cold Roast Beef—Dill Pickle**
25. Minced Beef—Broiled Tomato
26. Cold Roast Beef—Broiled Tomato
27. Baked Potatoes
28. ———
29. **Paprika Celery Curls**
30. ———
31. **Apple Tapioca, Whipped Cream, Chopped Walnuts**
32. Apple Tapioca
33. Vanilla Ice Cream
34. Sliced Fresh Peaches
35. Mixed Fruit Juice
36. **Pumpernickle Bread**

August 23

1. **Sliced Bananas in Orange Juice**
2. Orange Juice
3. **Corn Flakes or Granular Wheat Cereal**
4. **Poached Egg**
5. Grilled Ham
6. **Toast**

7. **Beef Bouillon**
8. **Toasted Crusts**
9. **Broiled Lamb Chop — Bacon**
10. Broiled Lamb Chop
11. **Creamed New Potatoes**
12. New Potatoes
13. **Okra Creole**
14. Green Peas
15. **Dolly Varden Salad (Fresh Pear and Plum)**
16. **French Dressing**
17. **Lemon Snow Pudding—Custard Sauce**
18. Lemon Snow Pudding—Custard Sauce
19. Lemon Snow Pudding
20. Pear and Plum Cup
21. Cherry Nectar

22. **Julienne Vegetable Soup**
23. **Saltines**
24. **Turkey and Noodle Casserole—Rose Radish**
25. Turkey and Noodle Casserole—Wax Beans
26. Hot Sliced Turkey—Wax Beans
27. Noodles
28. ———
29. **Asparagus, Pimiento Salad**
30. **Vinegarette Dressing**
31. **Fresh Fruit Compote**
32. Canned Peeled Apricots
33. Soft Custard
34. Fresh Berries
35. Apricot Nectar
36. **Cloverleaf Rolls**

August 24

1. **Fresh Plums**
2. Blended Juice
3. **Farina or Bran Flakes**
4. **Scrambled Egg**
5. Bacon
6. **Scotch Scones**

7. **Consomme**
8. **Crisp Crackers**
9. **Beef Chuck Roast—Gravy**
10. Roast Chicken
11. **Browned Potatoes**
12. Steamed Rice
13. **Quartered Carrots**
14. Spinach
15. **Waldorf Salad**
16. ———
17. **Fudge Cake with Coffee Ice Cream**
18. Coffee Ice Cream
19. Orange Sherbet
20. Ribier Grapes
21. Grape Juice

22. **Cream of Pea Soup**
23. **Melba Toast**
24. **Pan Broiled Liver with Spanish Sauce—Baked Stuffed Potatoes**
25. Broiled Liver
26. Broiled Liver
27. Baked Stuffed Potatoes
28. **Acorn Squash Rings**
29. **Orange and Blueberry Salad**
30. **French Dressing**
31. **Chilled Watermelon**
32. Angel Food Cake—Limeade
33. Coffee Ice Cream
34. Watermelon Balls
35. Tomato Juice
36. **Braided Rolls**

August 25

1. **Fresh Pear**
2. Grapefruit Juice
3. **Crisp Rice Cereal or Oatmeal**
4. **Soft Cooked Egg**
5. Canadian Bacon
6. **Toast**

7. **Blended Vegetable Juice**
8. ———
9. **Fried Haddock Fillets—Tartar Sauce**
10. Broiled Haddock
11. **Whipped Potatoes**
12. Whipped Potatoes
13. **Corn on Cob**
14. Asparagus Tips
15. **Marinated Whole Green Beans, Diced Onion and Celery Salad**
16. ———
17. **Rice Bavarian, Sliced Peaches**
18. Rice Bavarian
19. Strawberry Gelatin Whip
20. Honey Ball Melon
21. Cream of Spinach Soup

22. **Cream of Vegetable Soup**
23. **Whole Wheat Crackers**
24. **Tunafish Salad—Tomato and Lettuce Sandwiches**
25. Scalloped Salmon—Peas
26. Poached Salmon—Peas, Celery Hearts
27. Parslied Potatoes
28. ———
29. ———
30. ———
31. **Blackberries**
32. Fresh Applesauce
33. Baked Custard
34. Blackberries
35. Pineapple Juice
36. ———

August 26

1. **Orange Juice**
2. Orange Juice
3. **Rolled Wheat or Puffed Rice**
4. **Poached Egg**
5. Bacon
6. **Coffee Cake**

7. **Beef Bouillon**
8. **Crisp Crackers**
9. **Roast Pork—Gravy**
10. Broiled Veal Chop
11. **Paprika Potatoes**
12. Paprika Potatoes
13. **Butternut Squash**
14. French Green Beans
15. **Mixed Vegetable Salad**
16. **Herb French Dressing**
17. **Stewed Duarte Plums**
18. Tapioca Cream with Meringue
19. Cranberry Sherbet
20. Fresh Plums
21. Mixed Fruit Juice

22. **Cream of Asparagus Soup**
23. **Croutons**
24. **Chopped Steak on Open Toasted Bun—Pickle Chips**
25. Broiled Chopped Steak
26. Broiled Chopped Steak
27. Fluffy Rice
28. **Broiled Tomatoes**
29. **Green Cabbage Slaw**
30. **Cream Dressing**
31. **Fresh Applesauce, Oatmeal Cookies**
32. Jellied Canned Fruit
33. Raspberry Gelatin
34. Fresh Fruit Cup
35. Grapefruit Juice
36. ———

August 27

1. **Honeydew Melon**
2. Blended Juice
3. **Corn Flakes or Granular Wheat Cereal**
4. **Scrambled Egg**
5. Country Sausage
6. **Toast**

7. **Minted Orange Juice**
8. ———
9. **Fried Chicken**
10. Roast Chicken
11. **New Potatoes**
12. New Potatoes
13. **Sliced Carrots**
14. Spinach
15. **Molded Pineapple, Cucumber and Pecan Salad**
16. **Mayonnaise**
17. **Chocolate Almond Ice Cream**
18. Chocolate Ice Cream
19. Chocolate Rennet-Custard
20. Fresh Pineapple
21. Cream of Green Bean Soup

22. **Cream of Corn Soup**
23. **Saltines**
24. **Salad Bowl—Greens, Quartered Egg, Tomatoes — Peanut Butter and Bacon Sandwich**
25. Peach Half on Lettuce, Toasted Chicken Liver Sandwich
26. Broiled Lamb Cutlet—Vegetable Macedoine
27. Baked Potatoes
28. ———
29. **Celery Curls**
30. ———
31. **Stewed Cherries—Coconut Cake Squares**
32. Stewed Bing Cherries
33. Chocolate Ice Cream
34. Bing Cherries
35. Tomato Juice
36. ———

August 28

1. **Grapefruit Juice**
2. Grapefruit Juice
3. **Farina or Wheat and Barley Kernels**
4. **Poached Egg** (Omit on General)
5. Bacon
6. **French Toast—Syrup**

7. **Chicken Bouillon**
8. **Saltines**
9. **Meat Loaf, Tomato Sauce**
10. Roast Leg of Veal
11. **Mashed Potatoes**
12. Riced Potatoes
13. **Seven-Minute Cabbage**
14. Sliced Beets
15. **Hearts of Lettuce Salad**
16. **Roquefort Dressing**
17. **Peach Shortcake**
18. Baked Custard
19. Whipped Lime Gelatin
20. Sliced Fresh Peaches
21. Cherry Nectar

22. **Cream of Spinach Soup**
23. **Crisp Crackers**
24. **Scrambled Eggs and Noodles with Canadian Bacon**
25. Scrambled Egg, Crisp Bacon
26. Scrambled Egg, Chicken Liver
27. Noodles
28. **Peas**
29. **Tossed Salad**
30. **French Dressing**
31. **Fresh Pear and Grapes**
32. Tinted Pear and Rice Compote
33. Baked Custard
34. Seedless Grapes
35. Orange Juice
36. **Blueberry Muffins**

August 29

1. **Bananas**
2. Apricot Nectar and Lime Juice
3. **Crisp Corn Cereal or Rolled Wheat**
4. **Soft Cooked Egg**
5. Bacon
6. **Toast**

7. **Consomme**
8. **Crisp Crackers**
9. **Baked Ham Steak—Spiced Peach**
10. Broiled Liver
11. **New Potatoes in Cream**
12. Baked Potatoes
13. **Fresh Green Lima Beans**
14. Summer Squash Rings
15. **Celery Curls**
16. ———
17. **Lemon Pie**
18. Lemon Pudding
19. Raspberry Sherbet
20. Sliced Oranges
21. Orangeade

22. **Tomato Juice**
23. ———
24. **Chicken Chow Mein—Rice —Chinese Noodles**
25. Creamed Chicken
26. Hot Sliced Chicken
27. Steamed Rice
28. **Beet Tops**
29. **Melon Fruit Salad**
30. **French Dressing**
31. **Peppermint Stick Ice Cream—Chocolate Brownie**
32. Peach Whip
33. Floating Island
34. Fresh Pear
35. Beef Bouillon
36. **Toasted French Bread**

August 30

1. **Sliced Fresh Peaches**
2. Blended Juice
3. **Oatmeal or Wheat Flakes**
4. **Baked Egg**
5. Link Sausage
6. **Bran Muffins**

7. **Beef Bouillon**
8. **Melba Rye Toast**
9. **Roast Top Sirloin of Beef**
10. Roast Top Sirloin of Beef
11. **Franconia Potatoes**
12. Hominy
13. **Sliced Turnips**
14. Julienne Carrots
15. **Head Lettuce Salad**
16. **Chiffonade Dressing**
17. **Strawberry Bavarian**
18. Strawberry Bavarian
19. Mocha Sponge
20. Fresh Fruit Cup
21. Golden Punch

22. **Grapefruit Juice with Orange Sherbet**
23. ———
24. **Creamed Ham and Eggs on Corn Bread**
25. Broiled Lamb Pattie
26. Broiled Lamb Pattie
27. Potato Balls
28. **Asparagus Tips**
29. **Green Cabbage Slaw**
30. **Tarragon Dressing**
31. **Applesauce Cake, Lemon Icing**
32. Sliced Bananas
33. Soft Custard
34. Sliced Banana in Orange Juice
35. Tomato Bouillon
36. ———

August 31

1. **Cantaloupe**
2. Orange Juice
3. **Shredded Wheat or Hominy**
4. **Poached Egg**
5. Grilled Ham
6. **Toast**

7. **Blended Vegetable Juice**
8. ———
9. **Breaded Veal Chops**
10. Broiled Veal Chops
11. **Scalloped Potatoes**
12. Riced Potatoes
13. **Corn O'Brien**
14. Chopped Tender Greens
15. **Cucumber Salad**
16. **Sour Cream Dressing**
17. **Fresh Plum Cobbler**
18. Floating Island
19. Apricot Nectar Mold
20. Fresh Plums
21. Cream of Asparagus Soup

22. **Cream of Potato and Chive Soup**
23. **Saltines**
24. **Roast Beef Sandwich—Sliced Tomatoes**
25. Minced Beef on Toast—Beets
26. Cold Sliced Beef—Stewed Tomatoes
27. Baked Potatoes
28. ———
29. **Celery and Olives**
30. ———
31. **Lime Sherbet—Crisp Ginger Cookies**
32. Canned Peaches, Lime Sherbet Topping
33. Lime Sherbet
34. Fresh Pineapple
35. Grapefruit Juice
36. ———

NEWS

· · FEDERAL, LEGISLATIVE · ·

New Efforts Toward Reorganization

Efforts to reorganize federal hospitalization and health care activities were revived on Capitol Hill in June. Directly involved in the various plans now under consideration are the Hill-Burton hospital construction and expansion program, policies of Veterans Administration hospitalization, the question of whether the army, navy and air force should yield control of military hospitals to an independent civilian agency, and establishment of a Department of Health, Education and Security.

On June 13 and 14, the House Committee on Expenditures heard testimony by Eli Ginzberg, Ph.D., Columbia University economist, and George E. Ijams of the Veterans of Foreign Wars, opposing creation of a United Medical Administration which would centralize all governmental hospital and medical care operations in a single agency. The hearings were scheduled to continue but were interrupted when the committee had to give quick attention to a resolution disapproving President Truman's Reorganization Plan 27 on establishment of a Department of Health, Education and Security, to be headed by Federal Security Administrator Oscar R. Ewing.

Criticisms: Mr. Ginzberg, a wartime adviser to the army on hospital problems and known for his studies of hospitalization in New York State, criticized the conclusions of the Hoover Commission which led up to introduction of the United Medical Administration bill (H.R. 5182) by Representative Clare Hoffman (R., Mich.). He noted that only one member of the task force that advised the commission on health and medical matters—Maj. Gen. Paul R. Hawley—had intimate knowledge of the history and operations of federal medical services.

"The task force was determined to place a limit on the size of the Veterans Administration's hospital plant," said Mr. Ginzberg. "Apparently it was willing to do so irrespective of the needs of veterans or the alternative possibilities of meeting these needs. More than two-thirds of all the patients in Veterans Administration hospitals suffer from tuberculosis or mental diseases. And only 8 per cent of the accumulated patient days in Veterans Administration hospitals is accounted for by patients with a stay of less than 30 days.

"These facts must have been known to the members of the task force. Yet they recommended that in the future the federal government limit its assistance to general medical and surgical hospitals, in short, those which are best suited to care for the '8 per cent.' In view of the fact that the task force recognized that civilian facilities for the other 92 per cent are now 'very inadequate,' one is forced to conclude that they were willing to let this 92 per cent work out its own salvation. We know that the task force failed to put forward a practical alternative."

The Hoover Commission's task force, said Mr. Ginzberg, failed to appreciate that stripping the military of its hospitals and turning them over to a new civilian agency would be impracticable. It adhered to an unrealistic point of view with reference to hospitalization of veterans and made recommendations on operational economies that were not predicated on facts.

"I would consider it a grievous error if the Congress should enact H.R. 5182," the witness declared.

Suggests Planning Agency

The real need, he said, is for establishment of a top level planning agency that will appraise, quantitatively and qualitatively, the federal hospital system and harmonize its development with that of the nation's voluntary nongovernmental hospitals. Such a commission, he added, might be composed of three persons, nominated from private life, two of whom should be professionals, and it should have the services of a trained technical staff.

In this connection, a bill (H.R. 8647) was introduced in the House late in May by Representative Olin E. Teague (D., Texas) for setting up an Interagency Hospital Commission. It would perform the coordinating and planning functions which are now lacking, according to Mr. Ginzberg. The Teague plan, however, provides that medical heads of army, navy, air force, Veterans Administration and Public Health Service, along with four citizens from private life, shall comprise the commission. Mr. Ginzberg argued that federal officials should not serve on such a group, adding that their services should be in an advisory capacity only.

Testifying in behalf of Veterans of Foreign Wars, whose rehabilitation service he heads, Mr. Ijams urged defeat of H.R. 5182 on the ground it would be inimical to veterans' medical and hospital care. Similar testimony was presented by American Legion spokesmen at a one-day hearing held on the bill last April.

Month of decision: This month of July undoubtedly will witness congressional defeat or confirmation of President Truman's proposal to establish a Department of Health, Education and Security. Beaten on Capitol Hill last year, the plan has been somewhat revised. On June 13, Representative Hoffman introduced a resolution of disapproval, which must be approved by at least 218 members of the House—a constitutional majority—in order for Plan 27 to be beaten. As was the case in 1949, opposition is expected to be focused on the alleged unfitness of Federal Security Administrator Ewing to become secretary of the new executive department because of his espousal of compulsory national health insurance.

Opposition to the reorganization plan has been registered by the Citizens' Committee on the Hoover Report, which favors consolidation of federal hospital and health activities in a United Medical Administration. Plan 27 digresses from Hoover Commission recommendations, said a statement by the citizens' committee, in that it groups health, education and security together instead of putting

health in an independent agency like the U.M.A.; restricts authority of the Secretary of Health, Education and Security with the result that the department would be more of a "holding company," and fails to include the Bureau of Indian Affairs.

Annuities for Cures

An unusual bill (H.R. 8815) introduced in the House in mid-June provides for lifetime annuities of $100,000 each to the individuals who discover "general cures" for cancer, heart disease and poliomyelitis. In case of dispute over individual credits for any of the three discoveries, the Surgeon General of the Public Health Service would be arbiter. Sponsor of this measure is Representative Phil J. Welch (D., Wis.).

Health Reinsurance Bill

Representative Charles A. Wolverton (R., N.J.), the ranking minority member of House Interstate and Foreign Commerce Committee, is sponsor of the most noteworthy bill on promotion of the nation's health to be introduced in Congress last month. Known as H.R. 8746, it authorizes establishment of a Federal Health Reinsurance Corporation which would, in effect, enable Blue Cross and Blue Shield plans and health cooperatives to broaden their coverage features with the financial assurance that unusually heavy costs would be paid for, at least in part, by the corporation. The plan, embracing principles advocated by Harold E. Stassen, is similar to that of the Federal Deposit Insurance Corporation.

"The key point," said Representative Wolverton, "is that by reinsuring the heavier losses for health insurance it will be possible for the local Blue Cross, Blue Shield and other local farm cooperative and union hospitalization and medical care plans to give much more attractive contracts to the subscribers at a reasonable charge."

Inasmuch as Congress is not expected to adjourn before early August, it is still held possible — though not probable — that the House Interstate and Foreign Commerce Committee will conduct public hearings not only on the Wolverton bill but on the Administration's compulsory health insurance bill and the Bosone, Ives-Javits and other national health measures which have been introduced this year.

· · ORGANIZATIONS · ·

Catholic Hospital Association Meets

The 35th annual convention of the Catholic Hospital Association was held June 12-15 in Milwaukee, the city where the association was first organized.

About 4,000 delegates attended, coming from some 1,500 Catholic hospitals in the United States, Canada, Alaska and the Philippines. Several South American countries also sent representatives.

The official keynote of the convention was "strengthening voluntary hospitals through regional planning." On the second day of the convention, delegates heard Dr. Leonard A. Scheele, Surgeon General of the Public Health Service, call for meetings of hospital administrators, trustees, and medical staffs in individual communities to arrange for the interexchange of services between hospitals. Dr. Scheele said that cooperation on a community and regional basis is especially necessary to insure proper care for patients in small hospitals, and urged the Catholic sisterhoods to support a program for interhospital cooperation.

The Rev. Francis P. Lively, an associate director of diocesan welfare, Brooklyn, also stressed the need for community and regional planning, saying that, "No Catholic hospital can, in these days, consider itself an entirely independent unit and overlook its relationship in the area."

Regional cooperation. In an official resolution, the Catholic Hospital Association recommended a greater measure of regional cooperation between large and small hospitals, and emphasized the need for raising the level of service of small hospitals in each region.

Topics: In four general sessions, 15 sectional meetings (panel discussions), and seven special meetings, many current hospital problems were considered. Topics discussed included: The small hospital, hospitals and the practice of medicine, the place of the general practitioner in hospitals, public relations, requirements for a poliomyelitis service, administrative and departmental standards, developing personnel policies, financing hospital construction, and maintaining patient safety in the hospital.

Special consideration was given to proper integration of the general practitioner into hospital medical staffs. The association recommended that member hospitals organize educational programs for general practitioners and incorporate them into their medical staffs

Rt. Rev. Msgr. John R. Mulroy
President

Rt. Rev. Msgr. John J. Healy
President-elect

under conditions which would give them adequate recognition and also maintain a high quality of medical care for patients.

Officers: At one of the closing business sessions, new officers were named for the coming year. Msgr. John J. Healy, diocesan director of hospitals for Little Rock was named president-elect. He will serve in that capacity for one year and take over the president's position next year, succeeding Msgr. J. R. Mulroy of Denver.

An active member of the association, Msgr. Healy has served on its staff as a member of the administrative board. He is also a past trustee of the American Hospital Association.

Other officers elected were: Msgr. E. J. Goebel, Milwaukee archdiocesan director of hospitals, first vice president; Rev. Francis P. Lively, associate director of the Brooklyn diocesan hosptials, second vice president, and Sister Martha Mary, St. Clare's Hospital, New York, secretary. Sister Mary Seraphia of St. Louis was re-elected treasurer.

Re-elected to the executive board of the Catholic Hospital Association were: Sister Lydia, D. C., St. Vincent's Hospital, Indianapolis; Sister Mary Clare, St. Joseph's Hospital, Victoria, B. C.; Sister Mary Louise, S. S. J., St. Joseph's Hospital, Toronto, Ont., and Sister Mary Fidelis, St. Joseph's Hospital, Houston, Texas.

Newly elected to the executive board were: Sister Mary Veronica, R. S. M., Mercy Hospital, Baltimore, and Sister Hilary, Holy Cross Hospital, Salt Lake City.

Middle Atlantic

Robert W. Gloman, administrator of the Wilkes-Barre (Pa.) General Hospital, became president of the Middle Atlantic Hospital Assembly at the second annual meeting of the group in Buffalo, N. Y., May 24-26. More than 1,300 people were in attendance, not including exhibitors who displayed hospital products and materials in 117 technical exhibits.

Meeting at the same time as the regional organization were the hospital associations of New York, New Jersey and Pennsylvania and the regional and state associations of nurse anesthetists and medical record librarians.

Vice president of the Middle Atlantic Assembly is Anthony W. Eckert, director of Perth Amboy (N. J.) General Hospital and newly installed president of the New Jersey Hospital Association. Re-elected as secretary and treasurer were J. Harold Johnston, executive director of the New Jersey Hospital Association, and John F. Worman, executive secretary of the Hospital Association of Pennsylvania.

Upper Midwest

Installed as president of the Upper Midwest Hospital Conference, meeting in Minneapolis May 17-19, was Harold Wright, administrator of Methodist Hospital, Sioux City, Iowa. Nearly 3,000 persons, excluding those with the 140 commercial education exhibits, participated in the three-day meeting of the association and various allied groups.

Vice president of the conference and slated for the presidency next year is Harry C. Wheeler, administrator of Billings (Mont.) Deaconess Hospital. Glen Taylor, business manager of the Students' Health Service, University of Minnesota, was re-elected secretary and treasurer.

Pennsylvania

The 28th annual meeting of the Pennsylvania Hospital Association was held May 24-26 in Buffalo, N. Y., in conjunction with the Middle Atlantic Hospital Assembly. Special sessions on business administration and public relations were held on two days of the state association's meeting.

Alma M. Troxell, superintendent of Oil City Hospital, was elected to the presidency. Other officers for the coming year are:

First vice president, E. Atwood Jacobs, administrator, The Reading Hospital; second vice president, Sister M. Adele, assistant administrator, St. Francis Hospital, Pittsburgh, and treasurer, Robert W. Gloman, administrator, Wilkes-Barre General Hospital. John F. Worman, Harrisburg, was reappointed executive secretary of the association.

Delegates to the American Hospital Association are Miss Esther J. Tinsley, superintendent, Pittston Hospital; Harold T. Prentzel, administrator, Montgomery Hospital, Norristown, and Melvin L. Sutley, superintendent, Wills Eye Hospital, Philadelphia.

New York

Carl P. Wright Jr., superintendent of St. Luke's Hospital, Utica, was elected president of the Hospital Association of New York State at a meeting of the organization held May 24-26 in conjunction with the Middle Atlantic Hospital Conference, in Buffalo.

Other officers are: Vice presidents, F. Wilson Keller, director of the Hospital for Special Surgery, New York City, and Dorothy Pellenz, superintendent of Crouse-Irving Hospital, Syracuse; secretary, Carl P. Wright Sr., superintendent of the General Hospital of Syracuse, and treasurer, Moir P. Tanner, director of Children's Hospital, Buffalo.

New Jersey

The New Jersey Hospital Association met for three days, May 24-26, in conjunction with the Middle Atlantic Hospital Assembly in Buffalo. Anthony W. Eckert, director of Perth Amboy General Hospital, was installed as president, succeeding George C. Schicks, Sc.D., director of the Hospital of St. Barnabas, Newark.

Two general sessions were held, in addition to the association business session, at which panel discussions were presented on the general subjects: "Improving Hospital Services to the Public" and "Increasing Efficiency Within the Hospital."

President-elect of the association is W. Malcolm MacLeod, superintendent of the Elizabeth General Hospital. Other officers are: Vice president, William B. Meytrott, superintendent, William McKinley Memorial Hospital, Trenton, and treasurer, Howard S. Lyon, president, Somerset Hospital, Somerville, who was re-elected to the position. J. Harold Johnston is the executive director and secretary.

Delegates to the American Hospital Association are Dr. I. Ellis Behrman, director of Beth Israel Hospital, Newark, and Dr. Herbert M. Wortman, director of Mountainside Hospital, Montclair.

North Carolina

The North Carolina Hospital Association elected officers at a meeting of the organization on May 10 in Pinehurst. The president is F. Ross Porter, superintendent of Duke Hospital, Durham.

Other officers for the coming year are: President-elect, R. Z. Thomas, administrator of Charlotte Memorial Hospital, and secretary-treasurer, Sample B. Forbus, director of Watts Hospital, Durham. Mr. Porter is the delegate to the American Hospital Association, of which he is a trustee.

Minnesota

Officers for the coming year were elected by the Minnesota Hospital Association when 1,848 delegates attended the annual state meeting on May 17-19 in Minneapolis, at the same time the Upper Midwest Hospital Conference was in session. President of the state association is R. K. Swanson, superintendent of the Swedish Hospital, Minneapolis.

Other officers are: President-elect, Sister Mary Thomasine, superintendent, St. Gabriel's Hospital, Little Falls; first vice president, Mrs. Helen Rosenwald, administrator, St. Luke's Hospital, St. Paul; and second vice president, Ruby Gregerson, superintendent, Bethesda Hospital, Crookston. Re-elected to office were the secretary, Glen Taylor, business manager, Students' Health Service, University of Minnesota, Minneapolis, and treasurer, R. K. Fox, assistant superintendent, St. Luke's Hospital, Duluth.

Delegate to the American Hospital Association is James Stephan, associate professor of hospital administration, University of Minnesota, Minneapolis.

Indiana

Mrs. Helen Boyer, administrator of Dunn Memorial Hospital, Bedford, was installed as president of the Indiana Hospital Association at the annual meeting in Indianapolis.

President-elect is Sister Mary Ellen, administrator of St. John's Hickey Memorial Hospital, Anderson. Other officers are vice president, Ralph W. Keyes, administrator, Jackson County Schneck Memorial Hospital, Seymour, and treasurer, Maude Woodward, administrator, Clinton County Hospital, Frankfort.

New board members are Richard Hocking, Memorial Hospital, South Bend; Sister M. Geraldine, St. Joseph Hospital, Ft. Wayne, and Ralph Haas, Montgomery County Culver Hospital, Crawfordsville.

Albert G. Hahn, administrator of Protestant Deaconess Hospital, Evansville, was reappointed executive secretary.

Delegates to the one-day meeting also participated in a workshop on hospital purchasing, conducted by H. A. Larson, Healthwin Hospital, South Bend.

Arkansas

During the Arkansas Hospital Association's twentieth annual convention, held in Hot Springs May 30-31, John Gilbreath, administrator of Baptist Hospital, Little Rock, was installed as president for the coming year.

President-elect of the Arkansas association is Mr. K. W. Newman, administrator of University Hospital, Little Rock. Other officers are: Vice president, Sister Catherine Mary, St. Vincent's Hospital, Little Rock; secretary, John Cherry, assistant administrator, Davis Hospital, Pine Bluff, and treasurer, Lawrence Reding, assistant administrator, Sparks Memorial Hospital, Fort Smith. The delegate to the American Hospital Association is John A. Rowland, administrator, Trinity Hospital, Little Rock.

Meeting jointly with the hospital association were the Arkansas organizations of nurse anesthetists, dietitians and medical record librarians. Approximately 140 persons attended the meeting.

Oregon

The Oregon Association of Hospitals elected Franklin J. Smith, manager of Josephine County General Hospital, Grants Pass, to the presidency of the group for the coming year. Other officers elected by the association at its May 17-18 meeting in Hood River are:

President-elect, Wesley Lamer, administrator, Physicians and Surgeons Hospital, Portland; vice president, Sister Theodore Marie, administrator, Sacred Heart General Hospital, Eugene, and secretary-treasurer, William A. Zimmerman, assistant administrator, University of Oregon Medical School Hospital and Clinics, Portland.

William Gahlsdorf, business manager of Salem General Hospital, is delegate to the American Hospital Association, serving a two-year term.

Philadelphia

Officers of the Philadelphia Hospital Association were elected at a meeting of the group held on May 18. President is Daniel E. Gay, director of Lankenau Hospital.

Other officers are: Vice president, Sister Mary Michael, superintendent of Misericordia Hospital; secretary, George Benner, administrator of Northeastern Hospital of Philadelphia, and treasurer, Raymond H. Diament, administrator of Taylor Hospital, Ridley Park.

Members elected to the executive committee are George A. Hay, administrator of Hospital of the Women's Medical College of Pennsylvania; J. Don Miller Jr., administrator of Chestnut Hill Hospital, and Sister Mary Borgia.

New Mexico

Approximately 100 delegates attended the May 19-20 meeting of the New Mexico Hospital Association in Albuquerque, at which officers were elected for the coming year. Sister Mary Jude, registrar of St. Joseph Hospital, Albuquerque, was installed as president succeeding Roy W. Bashaw Sr., superintendent of Carrie Tingley Hospital in the town of Truth or Consequences.

Other officers elected by the association were: President-elect, F. O. McVey, administrator of Clovis Memorial Hospital; vice president, Dan Brown, administrator of Los Alamos Hospital, and secretary-treasurer, Hetty Silverman, record librarian, St. Joseph Hospital, Albuquerque.

Mr. F. C. Gabriel, superintendent of Southwestern General Hospital, Albuquerque, was elected delegate to the American Hospital Association.

At the business meeting of the association, delegates voted unanimously in favor of affiliation of the New Mexico Hospital Association with the American Hospital Association, and to collect dues simultaneously for both organizations.

Delegates voted also to establish a committee on administrative practice with Mr. Brown as chairman.

West Virginia

The West Virginia Hospital Association elected officers for the coming year during the meeting of the Carolinas-Virginas Hospital Conference in Charleston, S. C., on May 11 and 12.

President of the association is Thomas H. Mason, administrator, Oak Hill Hospital. Other officers elected were: President-elect, Paul J. Mehlinger, administrator of Monongahela General Hospital, Morgantown; vice president, Blair M. Patterson, administrator of St. Luke's Hospital, Bluefield, and re-elected secretary-treasurer, J. Stanley Turk, administrator of Ohio Valley General Hospital, Wheeling.

Delegate to the American Hospital Association is T. J. Lindberg, administrator of Fairmont General Hospital.

Administrative Residencies

Residency appointments for graduates of the nine university programs in hospital administration were announced last month. The residency year of on-the-job training is required of students working for a master's degree in hospital administration; in most cases it is required also of students working for a bachelor's degree.

In this year's listing there are more than a few physicians who have completed their medical training and are now working on an advanced degree in public health or hospital administration. One of the findings of the Kellogg Conference on university programs in hospital administration, held during May in Battle Creek, Mich., was that more medical students should be interested in the field of hospital administration.

Also enrolled in the university programs each year are students affiliated with the armed forces or Public Health Service who are assigned to federal hospitals for the year of residency.

Directors of the nine university programs in hospital administration which require a year of residency together with a year of academic work for a degree are:

Dr. F. R. Bradley, Washington University School of Medicine, St. Louis; James A. Hamilton, University of Minnesota, Minneapolis; R. L. Stull, University of California, Berkeley; Rev. John J. Flanagan, S.J., St. Louis University Graduate School; Dr. John E. Gorrell, Columbia University, New York City; Dr. Harvey Agnew, University of Toronto; George S. Buis, Yale University School of Medicine, New Haven, Conn., who succeeded Dr. Clement C. Clay on July 1; Dr. Malcolm T. MacEachern, Northwestern University, Chicago, and Dr. Arthur C. Bachmeyer, University of Chicago Clinics.

UNIVERSITY of California graduate students majoring in hospital administration: (Front row, left) Samuel J. Tibbitts; Jeannette H. Fessenden; Richard L. Johnston; (rear row, left) Dr. Harold H. Coder; Dr. Ivar R. Friman; Jack M. Scollard; Dr. Frank W. Threadgill.

Unless otherwise indicated, students on the following list are working for master's degrees in hospital administration. Students, preceptors and hospitals are:

WASHINGTON UNIVERSITY

ALDRIDGE, GERALD L., to Roy R. Prangley, superintendent of St. Luke's Hospital, Denver.

BERGSTEDT, DONALD R., to Dr. Robert H. Lowe, assistant medical director of Rochester (N. Y.) General Hospital.

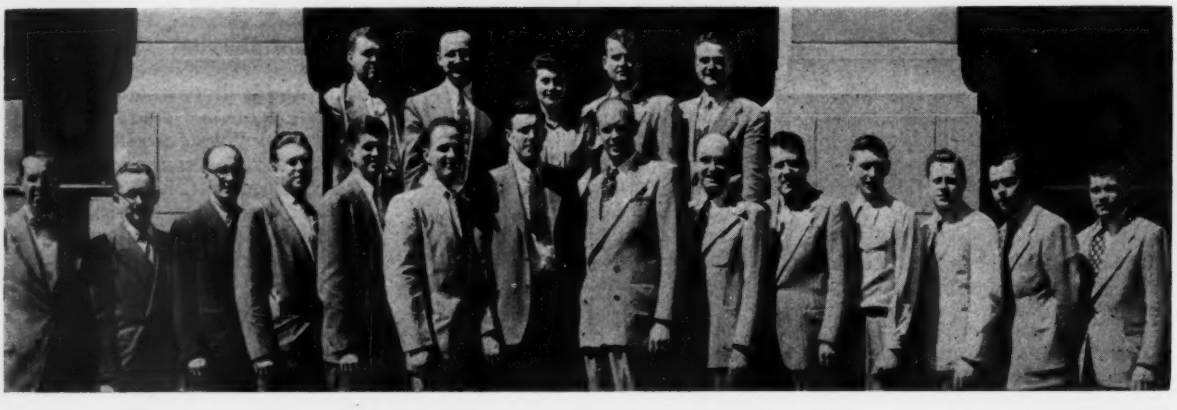
CROOKS, MARY L., to Dr. Frank R. Bradley, superintendent of Barnes Hospital, St. Louis, and Estelle Claiborne, director of St. Louis Children's Hospital.

ENOS, ROLAND, to Dr. T. E. Broadie, superintendent of Ancker Hospital, St. Paul.

GEE, DAVID A., to Florence King, administrator of Jewish Hospital, St. Louis.

HARDING, JAMES, to R. W. Bachmeyer, director of Aultman Hospital, Canton, Ohio.

WASHINGTON University, St. Louis, students of hospital administration: (Front row, left) Dr. Frank R. Bradley, director of the course; Grant Hoage; Captain C. W. Reeder; Stanley Martin; David Gee; Thomas Jones; Roland Enos; Harry E. Panhorst, associate director; Truman Yates; James Harding; Donald Bergstedt; Linn Perkins; Earl Rapp; Donald Horsh; (rear left) Gerald Aldridge; Hugh Vickerstaff; Mary L. Crooks; Garth Walker; Charles Ingersoll.



HOAGE, WILLIAM G., to Walter Hoefflin, administrator of Methodist Hospital of Southern California, Los Angeles.

HORSH, DONALD, to Dr. Curtis Lohr, superintendent of St. Louis County Hospital, Clayton, Mo.

INGERSOLL, CHARLES, to Gerhard Hartman, superintendent of State University of Iowa Hospitals, Iowa City.

JONES, THOMAS M., to Clyde Fox, administrator of Washoe Medical Center, Reno, Nev.

MARTIN, STANLEY W., to Jacques Cousin, assistant director of the Council of Rochester Regional Hospitals, Inc., and to Sister Inez, administrator of St. Mary's Hospital, Rochester, N. Y.

PERKINS, LINN B., to Dr. E. L. Harmon, director of Grasslands Hospital, Valhalla, N. Y.

RAPP, EARL LAMOINE, to Dr. Frank R. Bradley, superintendent of Barnes Hospital, St. Louis.

REEDER, CHARLES, to Captain L. Stone, medical officer of U. S. Naval Hospital, Bethesda, Md.

VICKERSTAFF, HUGH, to Dr. John W. Claiborne, medical director of Veterans Administration Hospital, Jefferson Barracks, Mo.

WALKER, GARTH, to Dr. C. C. Hillman, director of Jackson Memorial Hospital, Miami, Fla.

YATES, TRUMAN W., to Clarence Wonnacott, administrator of Latter Day Saints Hospital, Salt Lake City.

YALE UNIVERSITY

BUSHNELL, CLARENCE W., to Dr. Philip D. Bonnet, administrator of Massachusetts Memorial Hospitals, Boston.

DECKERT, ELIZABETH JANE, to Dr. Reo J. Marcotte, director of Pittsfield (Mass.) General Hospital.

GERDES, JOHN W., to Dr. James P. Dixon, director of Denver General Hospital.

YALE UNIVERSITY administration students on a field trip to Connecticut Hospital Service. (From left) Malcolm C. Hope; Adelaide E. Morris; John W. Gerdes; John J. Zugich; Clarence W. Bushnell; Raul E. Palma, M.D.; Elizabeth Jane Deckert; Connecticut Hospital Service staff members, Paul Dube, William Robson, assistant general manager, and K. M. Coleburn.

HOPE, MALCOLM C., to return to Public Health Service, Washington, D. C.

MORRIS, ADELAIDE E., to Dr. E. Stanley Grannum, administrator of Whittaker Memorial Hospital, Newport News, Va.

PALMA, RAUL E., M.D., to Dr. James P. Dixon, director of Denver General Hospital.

ZUGICH, JOHN J., to Dr. A. C. Kerlikowski, director of University Hospital, Ann Arbor, Mich.

UNIVERSITY OF CALIFORNIA

CODER, COL. HAROLD H., M.D., to a post in the European theater (master of public health degree).

FESSENDEN, JEANETTE H., to Gerhard Hartman, Ph.D., superintendent of State University of Iowa Hospitals, Iowa City (master of public health degree).

FRIMAN, IVAR A., M.D., M.B.A., to governmental service in Stockholm, Sweden (master of public health degree).

JOHNSTON, RICHARD L., to Dr. W. W. Stadel, administrator of San Diego (Calif.) County Hospital (master of public health degree).

SCOLLARD, JACK M., to W. B. Hall, administrator of University of California Hospital, San Francisco (master of public health degree).

THREADGILL, LT. COL. FRANK W., M.D., to William Beaumont General Hospital, El Paso, Texas (master of public health degree).

TIBBITTS, SAMUEL J., to Ritz E. Heerman, administrator of California Lutheran Hospital, Los Angeles (master of public health degree).

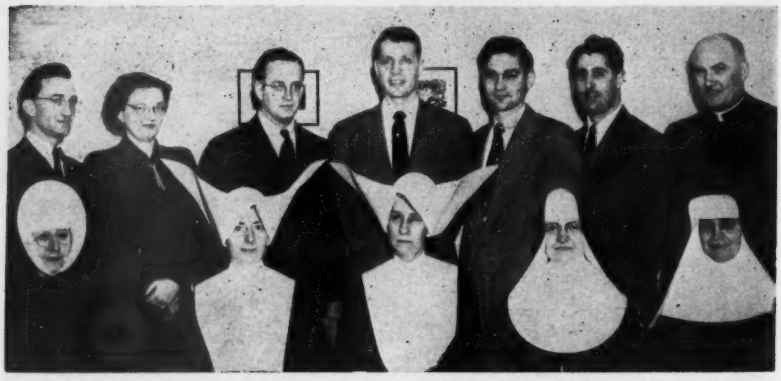
NORTHWESTERN UNIVERSITY

AMICARELLA, HENRY, to Dr. G. A. W. Currie, administrator of Colorado General Hospital, Denver.

AXELSON, NILS G., to Edgar C. Hayhow, Ph.D., administrator of East Orange (N.J.) General Hospital.

BALE, JOHN J., to E. Atwood Jacobs, administrator of The Reading (Pa.) Hospital.

NORTHWESTERN UNIVERSITY graduate students in hospital administration are pictured on one of the field trips made by the class.



ST. LOUIS UNIVERSITY: (Front, left) Sister Rose, F.C.S.P.; Sister Denise, D.C.; Sister Mary Elizabeth, D.C.; Sister Mary Stephanie, S.S.C.; Sister Mary Vincent, C.C.V.I. (Rear row, left) Rudolf J. Pondall and Margaret Foley, special lecturers; Raymond Riggs; Louis Prebil; Philip Lang; Victor E. Costanzo, associate director, and John J. Flanagan, S.J., acting director of the graduate school course in hospital administration at St. Louis University.

UNIVERSITY of Chicago hospital administration students completing work for master's degrees are: First row (from left) Everett A. Johnson, Victor Hernandez-Mendez, Bernard F. Carr, Paul Hofstad and James T. Googe Jr. Second row (from left) Edward A. Voss Jr., Frank Walter, Joseph P. Greer, George Wren, Dr. David Zaugg, Roger Klein and Sam Ruth.

UNIVERSITY OF MINNESOTA graduate students in the course in hospital administration. (Front, left) H. Gregg Armitage; Thomas L. Hollis; Lloyd L. Hughes; Donald A. Kincaid; Professor James A. Hamilton; Gaylord W. Anderson, M.D.; James W. Stephan, associate professor; Herman E. Hoche; Preston L. Powell; (row 2, left) William H. Waite; Frederic C. LeRocker; James R. Neely; William C. Hoppe; Dale C. Mattison; Norman L. Kaye; Marcelo G. Leite, M.D.; Richard P. Condelaro; John A. Nelson; Rudolph F. Elstad; (rear row, left) Oliver R. Johnson; Harold E. Dale; Wade Mountz; Edward D. Irons; Clifford R. Rostomily; Russel H. Miller; Howard M. Winholtz; Jack W. Rivall; Carl N. Platou; James W. Mainguy.

BARDEN, NORMA, to Dr. P. F. Lucchesi, director of Philadelphia General Hospital.

BROTHERTON, GEORGE T., to Rev. B. Boone, administrator of Methodist Hospital, Dallas.

CARLISLE, BENNY T., to Boone Powell, administrator of Baylor University Hospital, Dallas.

CIPALA, MARIAN F., to Arthur L. Bailey, administrator of Jefferson-Hillman Hospital, Birmingham.

DETRICK, PAUL F., to Bruce Dickson, superintendent of Bethany Hospital, Kansas City, Kansas.

FERGUSON, JAMES E., to Dr. R. S. Gass, director, Division of Tuberculosis Control, State of Tennessee, Department of Health, Memphis, and supervisor, East Tennessee Tuberculosis Hospital, Knoxville.

GETTMAN, JOHN C., to Jack A. L. Hahn, superintendent of Memorial Hospital of Sandusky County, Fremont, Ohio.

HALL, DWAYNE L., to S. A. Ruskjer, Deputy Director of Health for Louisville and Jefferson County in Charge of Hospitals; administrator of Waverly Hills Sanatorium, Waverly Hills, Ky.

HILL, WALDO A., to Boone Powell, administrator of Baylor University Hospital, Dallas.

JACOBSON, ROBERT T., to Dr. A. F. Branton, administrator of Baroness Erlanger Hospital, Chattanooga.

LILLI, JOSEPH A., to Sidney Bergman, administrator of Montefiore Hospital, Pittsburgh.

MCHUGH, RAYMOND T., to Alfred E. Maffly, administrator of Herrick Memorial Hospital, Berkeley, Calif.

MAY, FREEMAN, to Frank S. Groner, administrator of Baptist Memorial Hospital, Memphis.

MOBURG, KENNETH D., to Dr. Kenneth Babcock, director of the Grace Hospital, Detroit.

MONARDO, GEORGE D., to Arthur J. Will, Superintendent of Charities, Los Angeles County.

NICHOLS, MARVIN W., to Harold Wright, superintendent of Methodist Hospital, Sioux City, Iowa.

OBERG, ALBIN H., to William S. Brines, director of the Malden (Mass.) Hospital.

QUINN, JAMES W., to A. L. Bailey, administrator of Jefferson-Hillman Hospital, Birmingham.

QUITTMEYER, ERNEST W., to Richard D. Vanderwarker, director of Passavant Memorial Hospital, Chicago.

SANDAHL, ROBERT A., to William L. Coffey, administrator of Milwaukee County Institutions.

SCALZO, DONALD F., to Hans S. Hansen, administrator of Grant Hospital, Chicago.

SEJNOST, RICHARD L., to Dr. E. Dwight Barnett, director of Harper Hospital, Detroit.

SMITH, CARLOS J. R., to J. M. Crews, superintendent of Methodist Hospital, Memphis.

WALDO, PROCTOR L., to Ralph M. Hueston, superintendent of Wesley Memorial Hospital, Chicago.

WICKHAM, NED W., to D. O. McCluskey Jr., administrator of Druid City Hospital, Tuscaloosa, Ala.

COLUMBIA UNIVERSITY

CONNOR, PAUL J., JR., to Dr. Wilmar M. Allen, director of Hartford (Conn.) Hospital.

CULP, CURTIS F., M.D., to John Parke, executive vice president of Presbyterian Hospital, New York City.

DU FLON, LEON W., to Dr. James Bordley III, director of the Mary Imogene Bassett Hospital, Cooperstown, N. Y.

ESPONOSA, TULIO, M.D., to Dr. Leonard J. Goldwater of the School of Public Health, Columbia University, New York City.

GORDON, EDWARD M., M.D., to Public Health Service, Portland, Maine.

HEINLEIN, ROBERT E., to Frank P. Sauer, superintendent of Muhlenberg Hospital, Plainfield, N. J.

JONES, ROBERT M., to Joseph G. Norby, superintendent of Columbia Hospital, Milwaukee.

LAWRENCE, MARVIN J., to Dr. David H. Ross, executive director of Jewish Hospital, Cincinnati.

MARTINEZ, SIGIFREDO G., to Carl Miller, assistant administrator of New York University Hospital, New York City.

NICKLAS, JOHN M., to Dr. William B. Seymour, director of Lakeside Hospital, Cleveland.

NORK, JURT H., to Dr. Henry N. Pratt, director of the Society of the New York Hospital, New York.

PARKS, HAROLD C., to D. A. Endres, superintendent, Youngstown (Ohio) Hospital Association.

PEPPER, JAMES R., to Dr. E. Dwight Barnett, director of Harper Hospital, Detroit.

PERKINS, THEODORE D., to Charles E. Burbridge, superintendent of Freedmen's Hospital, Washington.

PIERATT, RICHARD E., to Dr. A. P. Merrill, superintendent of St. Barnabas Hospital for Chronic Diseases, New York City.

POOLE, WILEY G., to Dr. Robin C. Buerki, vice president in charge of

A Fund Raising Organization
• of Hospital Experts
• for Hospital Campaigns

(25 years of successful experience in the hospital field)

EXAMPLES OF SOME OF OUR RECENT CAMPAIGNS

Annapolis Emergency Hospital	June, 1949
Annapolis, Maryland	Population: 13,069
Goal (for New Wing)	$350,000
Raised	$508,315
Number of Gifts	4,820
Total Cost (Including both fixed fee and all campaign expenses)	6.0%

★ ★ ★

Corning Hospital	February, 1949
Corning, New York	Population: 16,212
Goal (for New Wing)	$325,000
Raised	$451,600
Number of Gifts	7,894
Total Cost (Including both fixed fee and all campaign expenses)	5.7%

★ ★ ★

***Peninsula General Hospital**	May, 1949
Salisbury, Maryland	Population: 10,313
Goal (for New Wing)	$350,000
Raised	$473,725
Number of Gifts	3,798
Total Cost (Including both fixed fee and all campaign expenses)	6.2%

*Our second successful campaign for Peninsula General Hospital.

★ ★ ★

As this advertisement goes to press we have successfully concluded hospital campaigns in Minot and Fargo, N. Dak.; Crookston, Minn. and Batavia, N. Y. We are also serving Valley City, Jamestown and Bismarck, N. Dak.; St. Paul, Minn.; Princeton, Ill. and a third Haney campaign in Sandusky, O.

When your Board's next fund raising problem arises, your first move toward campaign victory will be to request a Haney consultation . . . without any obligation or expense. Write for complimentary reprint of *HOSPITALS* article "Preliminaries to a Successful Fund Drive."

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ASSOCIATES, INC.

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NEWTONVILLE 60, MASSACHUSETTS

medical affairs, University of Pennsylvania, Philadelphia.

PORTER, FRANK L., III, to Dr. Lucius R. Wilson, superintendent of Episcopal Hospital, Philadelphia.

RAMIREZ, ALFONSO, M.D., to Dr. Nathan Smith, medical superintendent of Morrisania Hospital, New York City.

ROBINSON, J. EMERSON, to Dr. Robin C. Buerki, vice president in charge of medical affairs, University of Pennsylvania, Philadelphia.

SAGE, FREDERICK C., to Dr. Anthony J. J. Rourke, physician superintendent, Stanford University Hospitals, San Francisco.

SLEIGHT, ROBERT E., to Dr. Eugene Walker, superintendent of Springfield (Mass.) Hospital.

STOUT, ROBERT D., to George H. Buck, director of University Hospital, Baltimore.

TOOMEY, ROBERT E., to Dr. John B. Pastore, executive director, Hospital Council of New York City.

to balance budgets...

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Now . . . hospitals can meet *both* their professional requirements and their budgetary limitations with the new *Hospital Package* of YALE Hypodermic Syringes. Economies in packaging and handling permits real savings on 2, 5 or 10 cc. syringes with Glass Tip, Luer-Lok or Metal Luer Tip in packages of *3 dozen of a single type and size.*

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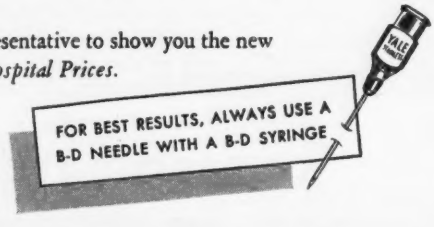
Ask your dealer or B-D representative to show you the new *Hospital Package* at special *Hospital Prices.*



B-D PRODUCTS
Made for the Profession

BECTON, DICKINSON AND COMPANY, RUTHERFORD, N. J.

WALCHENBACH, DONALD E., to Paul J. Spencer, director of Lowell (Mass.) General Hospital.

WHYTE, HENRY J., to Charles E. Burbridge, superintendent of Freedmen's Hospital, Washington, D. C.

UNIVERSITY OF MINNESOTA

ARMITAGE, H. GREGG, to U. S. Navy Hospital, St. Albans, N. Y.

BERNADINE, SISTER M., to Holy Cross Hospital, Detroit, where she is administrator.

DALE, HAROLD E., to William P. Butler, manager of San Jose (Calif.) Hospital.

ELSTAD, RUDOLPH F., to Walter M. Oliver, administrator of Children's Hospital, San Francisco.

HOCHE, HERMAN E., to U. S. Navy Hospital, Philadelphia.

HOLLIS, THOMAS L., to U. S. Navy Hospital, National Navy Medical Center, Bethesda, Md.

HOPPE, WILLIAM C., to Frank J. Walter, administrator of Good Samaritan Hospital, Portland, Ore.

HUGHES, LLOYD L., to Oliver G. Pratt, executive director of Rhode Island Hospital, Providence.

IRONS, EDWARD D., to Bryce L. Twitty, administrator of Hillcrest Memorial Hospital, Tulsa, Okla.

JOHNSON, OLIVER R., to Boone Powell, administrator of Baylor Hospital, Dallas.

KAYE, NORMAN L., to Dr. Peter D. Ward, director of Charles T. Miller Hospital, St. Paul.

KINCAID, DONALD A., to Ray Amberg, director of the University of Minnesota Hospitals, Minneapolis.

LEITE, MARCELO G., M.D., to Dr. James P. Dixon, director of Denver General Hospital.

LE ROCKER, FREDERIC C., to Leon Hickernell, director of Vancouver (B.C.) General Hospital.

MAINGUY, JAMES W., to Jacques Cousin, assistant director of Council of Rochester (N.Y.) Regional Hospitals, Inc.

MATTISON, DALE C., to George Bartel, superintendent of St. Barnabas Hospital, Minneapolis.

MILLER, RUSSEL H., to W. L. Wilson, administrator of Mary Hitchcock Memorial Hospital, Hanover, N.H.

MOUNTZ, WADE, to Arden E. Hardgrove, superintendent of Norton Memorial Infirmary, Louisville, Ky.

NEELY, JAMES R., to Dr. Gerald W. Sinnott, assistant to director, Jersey City (N.J.) Medical Center.

NELSON, JOHN A., to Raymond Swanson, superintendent of Swedish Hospital, Minneapolis.

PLATOU, CARL N., to Russell Nye, administrator of Northwestern Hospital, Minneapolis.

POWELL, PRESTON L., to U. S. Navy Hospital, Pensacola, Fla.

RIVALL, JACK W., to James McNee, superintendent of St. Luke's Hospital, Duluth.

ROSTOMILY, CLIFFORD R., to M. E. Knisely, administrator of St. Luke's Hospital, Milwaukee.

WAITE, WILLIAM H., to Miriam Curtis, superintendent of Syracuse (N.Y.) Memorial Hospital.

WINHOLTZ, HOWARD M., to Ray Amberg, director of University of Minnesota Hospitals, Minneapolis.

SAINT LOUIS UNIVERSITY

DUNLEAVY, SISTER CECILIA, to Sister Loretto Bernard, administrator of St. Vincent's Hospital, New York City.

BURKE, SISTER DENISE, to Sister Rose Alexis, administrator of Hospital of St. Raphael, New Haven, Conn.

BERRY, SISTER MARY ELIZABETH to Sister Loretto Bernard, administrator of St. Vincent's Hospital, New York City.

BALCIUNAS, SISTER M. STEPHANIE to Sister M. Dorothea, administrator of Loretto Hospital, Chicago.

LANG, PHILIP JOSEPH to Dr. J. L. Mackenzie, administrator of Touro Infirmary, New Orleans.

PREBIL, LOUIS EDWARD to Sister M. Harriet, administrator of St. Mary's Hospital, Minneapolis.

RIGGS, RAYMOND TURNER to Dr. David Littauer, administrator of Menorah Hospital, Kansas City, Mo.

UNIVERSITY OF TORONTO

ARMITAGE, DICKSON T., to Dr. W. Douglas Piercey, superintendent of Ottawa (Ont.) Civic Hospital.

FLEETWOOD, RAYMOND A., to Gerhard Hartman, superintendent of State University of Iowa Hospitals, Iowa City.

HORNSTEIN, JOSEPH, to Samuel S. Cohen, superintendent of Jewish General Hospital, Montreal.

JOHNSON, STACY, to Harold Prather, administrator of East Tennessee Baptist Hospital, Knoxville.

LA SALLE, G., M.D., to Dr. J. Gilbert Turner, superintendent of Royal Victoria Hospital, Montreal.

LEE, JOHN C., to Dr. John B. Neilson, superintendent of Hamilton (Ont.) General Hospital.

MCNAB, JAMES A., to Leon Hickernell, director of Vancouver (B. C.) General Hospital.

PEARCE, RICHARD J., to Dr. Carman J. Kirk, superintendent of

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FAN-PLAN
WITH EMERSON-ELECTRIC OSCILLATORS
Exclusive! EMERSON-ELECTRIC 5-YEAR FACTORY-TO-USER GUARANTEE at No Extra Charge
Stationary hollow-steel shaft is case-hardened and rigidly anchored in the motor frame.
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APPLIANCES

the Victoria Hospital, London, Ont.

PEART, DOUGLAS R., to W. E. Leonard, superintendent of Toronto East General Hospital.

SILVERSIDES, FRANKLIN H., to Dr. Wallace R. Grant, superintendent of Children's Hospital, Winnipeg, Man.

STEWART, GERALD C., to Dr. Basil MacLean, director of Strong Memorial Hospital, Rochester, N.Y.

WETZEL, HAROLD E., to John G. Dudley, administrator of Baptist Memorial Hospital, Houston, Tex.

UNIVERSITY OF CHICAGO

CARR, BERNARD, to J. B. H. Martin, administrator of Indiana University Medical Center, Indianapolis.

GOOGE, JAMES T., JR., to Hal G. Perrin, administrator of Bishop Clarkson Memorial Hospital, Omaha.

GREER, JOSEPH, to Reid T. Holmes, administrator of North Carolina Baptist Hospital, Winston-Salem.

HERNANDEZ, VICTOR, to Brooke Army Medical Center, Ft. Sam Houston, Texas.

HOFSTAD, PAUL, to William O. Bohman, superintendent of Norwegian-American Hospital, Chicago.

JOHNSON, EVERETT A., to J. Milo Anderson, superintendent of Methodist Hospital, Gary, Ind.

KLEIN, ROGER, to Stanley A. Ferguson, superintendent of Cleveland City Hospital.

RUTH, SAM, to Dr. Charles F. Wilinsky, executive director of Beth Israel Hospital, Boston.

VOSS, EDWARD A., JR., to Dr. G. Otis Whitecotton, medical director of Highland-Alameda County Institutions, Oakland, Calif.

WALTER, FRANK, to Dr. Robin C. Buerki, vice president in charge of medical affairs, University of Pennsylvania, Philadelphia.

WREN, GEORGE, to Robert E. Neff, superintendent of Methodist Hospital, Indianapolis.

ZAUGG, DAVID, M.D., medical director of Marine Hospital, Stapleton, Staten Island, N. Y.

Awards to Graduates

Two graduate students in hospital administration at Northwestern University received awards last month for outstanding work. Both received master's degrees in hospital administration in June.

The Malcolm T. MacEachern award, consisting of a silver medal and $250, was presented to Richard D. Vanderwarker, director of Passavant Memorial Hospital, Chicago. Mr. Vanderwarker has been at Passavant Hospital since 1947 and took his graduate studies concurrently with his work. The MacEachern award is provided each year by the Johnson & Johnson Research Foundation.

MISS GRAHAM

MR. VANDERWARKER

Martha Elizabeth Graham of Akron, Ohio, received the Mary H.

QUALITY CONTROL In the Manufacture of Pure Latex Surgical Tubing

The young lady above is inspecting surgical tubing as it runs through a dipping machine. This close control in the making of RLP Pure Latex Surgical Tubing starts with the raw liquid latex. Each succeeding step in the manufacturing process — right up to the packaging of the finished surgical tubing — is subject to rigid inspections and controls.

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McGaw award of a citation and $200, provided by Foster G. McGaw, president of the American Hospital Supply Corporation. Miss Graham is assistant to the administrator of Peoples Hospital, Akron.

Northwestern Graduates

Fifty degrees in hospital administration were conferred by Northwestern University in June. Including the class this year, 169 students have received degrees in hospital administration since the course was started in September 1943.

In the following list of graduates, master's degrees were awarded unless otherwise indicated.

ANDERSON, WILLIAM L., administrator of East Side General Hospital, Detroit.

ANGULO-ARVELO, LUIS A., M.D., Hospital Division, Ministerio Sanidad and Asistencia Social of Venezuela, Caracas.

ASKUE, PAUL W., Metropolitan Life Insurance Company, Chicago.

AUSTIN, PHILIP A., assistant manager of Mrs. Austin's Nursing Home, Seattle.

BEAUDRO, LEA GRACE, R.N., administrator of St. Luke's Hospital, Kearney, Neb. (Bachelor's degree.)

BENNETT, HARVEY ERNEST., assistant treasurer of the Mennonite Board of Missions and Charities, Elkhart, Ind.

BESHEARS, MANSFIELD, JR., administrator of Elk City (Okla.) Hospital.

BURGIN, HORACE L., administrator of Burge Memorial Hospital, Springfield, Mo. (Bachelor's degree.)

BYRD, J. C., Groves, Texas. (Bachelor's degree.)

CAMPBELL, ROBERT V., administrator of Mercy Hospital, Oscaloosa, Iowa.

CHENG, PEARL MING, R.N., administrative assistant of Presbyterian Mission Hospital, Hengyang, China.

CONSTANTINE, DAVID, New York City.

DAMIANI, EILEEN, R.N., administrator of Madison (S.D.) Community Hospital.

ETSWEILER, JOHN W., JR., assistant director of the Malden (Mass.) Hospital.

FUGLE, KATHRYN M., R.N., Washington, D. C.

FULCHER, R. B., Postoak, Texas.

GRAHAM, MARTHA ELIZABETH, assistant to the administrator of Peoples Hospital, Akron, Ohio.

GREENE, CHARLES J., administrative assistant in charge of purchasing and personnel at Provident Hospital, Chicago.

HARE, TRACY B., administrator of Children's Hospital, Miami, Fla. (Bachelor's degree.)

HAWKINS, REUBEN EDWIN, JR., Dallas.

HEINZE, CARL, consultant, Hospital Division, Indiana State Department of Health, Indianapolis.

HENRY, JOSEPH, administrator of Parkland Hospital, Rochester, N. Y.

HUBBARD, FREDERICK C., JR., administrator of Wilkes Hospital, North Wilkesboro, N. C.

HURON, JAMES A., administrative assistant of Veterans Administration Hospital, Vancouver, Wash.

JAMES, JOHN T., administrator of Memorial Hospital, Carthage, Ill.

KROHN, FLOYD F., R.N., Watertown, S. D.

MCALOON, JOSEPH F., R.N., consultant in hospital administration,

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SAFE·QUICK GERMICIDE
SAN PHENO X has an amazing success story in the hospitals of the nation. It was one of the first pleasant smelling yet powerful non-specific germicides. Best of all, San Pheno's low cost made possible the use of one germicide for every job on animate or inanimate surfaces. Diluted 1 to 200, it is effective on E. Typhi, Staph Aureus and T. B. germs, even in the presence of organic matter. Does not corrode or dull instruments. Can be used safely at recommended dilutions on human tissue as well as rubber or metal. Write for sample.
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PLEASANT ODOR · NON TOXIC · POWERFUL
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Hospital Planning Division, Florida State Improvement Commission, Tallahassee. (Bachelor's degree.)

McNELLEY, JAMES E., administrative assistant of Hollywood (Calif.) Presbyterian Hospital.

MILLIS, MAUDE EVELYN, R.N., assistant administrator of Hayswood Hospital, Maysville, Ky. (Bachelor's degree.)

MOSS, JAMES H., JR., administrator of Defiance (Ohio) Municipal Hospital.

NELSON, PAUL W., business manager of Seward (Alaska) Sanatorium.

PAGAN-CARLO, JOSUE, medical student at Tulane University of Louisiana School of Medicine, New Orleans.

PILON, HAROLD J., Louisville, Ky.

RAMOS, ANTONIA, R.N., Superintendent of Clinica Quirurgica de Dr. Pila, Ponce, Puerto Rico. (Bachelor's degree.)

RILEY, ALFRED E., administrator of Contagious Disease Hospital, Chicago. (Bachelor's degree.)

RINKER, CARL D., business manager of Independence (Iowa) State Hospital.

ROY, RALPH L., administrator of Memphis Eye, Ear, Nose and Throat Hospital.

RYBERG, ERNEST E., administrator of Anna (Ill.) City Hospital. (Bachelor's degree.)

SANDERS, MARJORIE ANN, R.N., assistant administrator of Women's Hospital, Flint, Mich.

SCRUGGS, RICHARD F., assistant administrator of Jefferson-Hillman Hospital, Birmingham, Ala.

SEARS, BURTON N., administrative assistant of City-County Hospital, Dallas.

SEGALL, MANUEL J., Chicago.

SHEPPECK, MICHAEL L., M.D. (Col., U. S. Army), executive officer of Walter Reed General Hospital, Washington, D. C.

SWANSON, ARNOLD L., M.D., deputy medical superintendent of Provincial Mental Hospital, Essondale, B. C.

TERENZIO, PETER B., assistant administrator of Roosevelt Hospital, New York City.

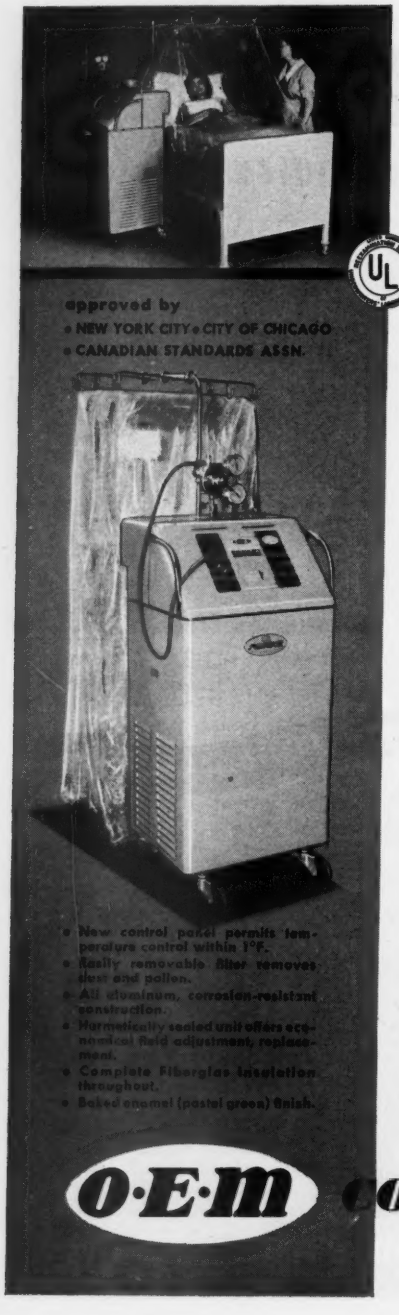
TOLSON, EDWARD L., JR., Division of Medical and Hospital Resources, Public Health Service, Washington, D. C.

VANDERWARKER, RICHARD D., director of Passavant Memorial Hospital, Chicago.

VOLGA, STANLEY W., R.N., Sioux City, Iowa.

WILCOX, CHARLES R., M.D. (Capt., U. S. Navy), executive officer of Saint Albans (N. Y.) Naval Hospital.

WILLIAMS, WILLIAM R., assistant administrator of Research and Educational Hospitals, University of Illinois, Chicago.


approved by
• NEW YORK CITY • CITY OF CHICAGO
• CANADIAN STANDARDS ASSN.
• New control panel permits temperature control within 1°F.
• Easily removable filter removes dust and pollen.
• All aluminum, corrosion-resistant construction.
• Hermetically sealed unit offers economical field adjustment, replacement.
• Complete Fiberglas insulation throughout.
• Baked enamel (pastel green) finish.

NOW-The O·E·M ICELESS MECHANAIRE

The Only Tent Of Any Type Ever Accepted by Underwriters' Laboratories June 23, 1949

Here is another new contribution by O.E.M. to better oxygen therapy—the O.E.M. Mechanaire. This new iceless oxygen tent, first to be awarded the approval of the Underwriters' Laboratories, is a major contribution to the profession, offering features of safety, efficiency and economy never obtainable before.

Of major importance to users, the O.E.M. Mechanaire coil will not freeze up (ice) regardless of humidity or weather conditions. Perfectly balanced air conditioning prevents deposition of moisture on coil with consequent icing—permits instant, even thermostatic control of temperature, humidity. No defrosting is necessary.

The O.E.M. Mechanaire is also equipped with the *full-bed* O.E.M. Cleerlite Transparent Permanent Canopy (thickness, 5 mil). It is waterproof, will not pit or stipple in oxygen, is resistant to air, alcohol, acids—does not deteriorate or become brittle.

The O.E.M. Mechanaire is the lightest oxygen tent available today, weighing only 160 pounds. It handles easily with practically no effort.

There are still other important features you should know about the O.E.M. Mechanaire. Write today for our new catalog.

O·E·M CORPORATION

(Oxygen Equipment Mfg. Corp.)
FITCH ST., EAST NORWALK, CONN.

More Medical Students

The Ohio State University College of Medicine recently announced that 150 freshmen medical students will be admitted to the school this fall, a big increase over the quota of 88 students in previous years. Resulting from the expansion, the Ohio school will rank among the nation's leaders in total enrollment.

New York state's newly acquired medical school at Syracuse will be enlarged to accommodate 100 students per class. Seventy-five freshmen were admitted in September 1949, and there will be 75 in this year's class.

Lower Operating Costs

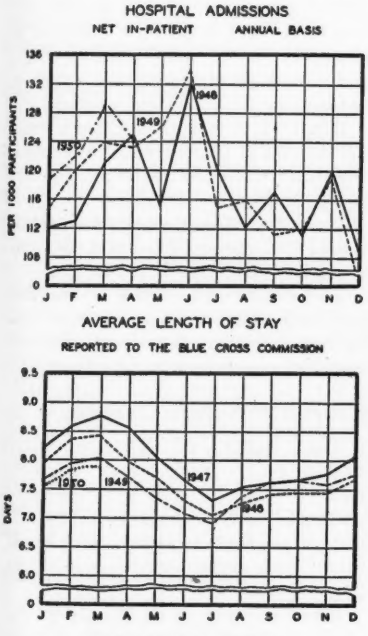
Operating expenses of Blue Cross plans during the first quarter of 1950 were 8.37 per cent of the total income, or $9,184,564. This was a reduction from the first quarter figure of 1949, which amounted to 9.30 per cent.

Payments for hospitalized members covered by Blue Cross amounted to $96,989,972, or 88.35 per cent of the total income earned during the first quarter of 1950. Payments in the first quarter of 1949 amounted to 87.54 per cent of total income earned.

The net income for all Blue Cross plans, or the amount remaining after hospital payments and operating expenses were deducted from total income, was $3,626,765, or 3.30 per cent of the total income earned during the first quarter of 1950.

Record-Breaking Month

During May of this year the Blue Cross Commission's Inter-Plan Service Bank had the busiest month in its history. There were 8,970 cases paid involving 66,006 days of hospital care. Hospitals received $784,919.28 for patient service during the month. Sixty-five Blue Cross plans now are participating in the bank.



ADMISSION STAY

The average inpatient rate for Blue Cross plan patients in April was 124 per thousand, a decrease of 3.97 over the March rate which was 129 per thousand. A year ago in April 1949 the inpatient admission rate was slightly lower, 123 per thousand. The monthly figures for 1950 have thus far been higher than figures for the same months last year.

The average length of stay for March was 7.87 days, an increase of .06 days over the February rate of 7.81 days. This is .14 days less than the average length of stay for March 1949 which was 8.01 days.

"Made real purty, but whut's it fer?"

That looks like a Rongeur you're holding, Sacramento Sam. It probably was made by Fred Haslam & Co., who started to make surgical instruments in 1848 (the same year your grandpappy dug for gold at Sutter's Mill). And the time your grandpappy stopped that claim-jumper's bullet, it's quite possible that an old model Haslam instrument helped clean up his clavicle where the .44 slug had smashed it to splinters. *For even in the first year of their production, Haslam Instruments were accepted as ideally suited to the needs of the medical profession.*

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Preliminary T-P-R Winners

Nine preliminary winners of the T-P-R contest, a featured event of the 52nd annual convention of the American Hospital Association, have been announced by the contest judges. The 1950 convention will be held in Atlantic City, Sept. 18-22, with headquarters at the Traymore Hotel.

More than 100 entries were received, each one representing an original technique, procedure or routine devised by a hospital to make its operations more efficient and to offer better service. Contest entries ranged from a mop cleaning and storage device to a wheel cart fitted for repair purposes throughout the hospital.

A demonstation will be given at the convention of each of the nine winning ideas. After the demonstration, final selection of the winners will be made with the use of applause meters.

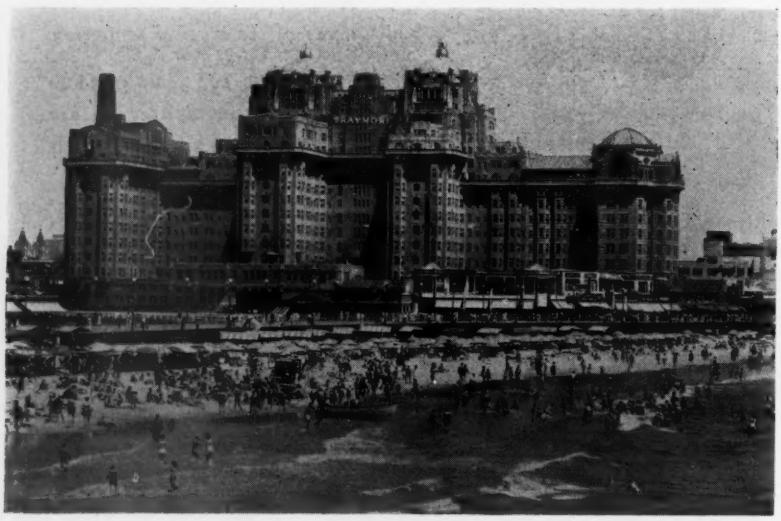
The hospitals and administrators which have been judged to show the greatest ingenuity in developing new equipment or methods are:

ROBERT E. NEFF, superintendent of Methodist Hospital of Indiana, Indianapolis, who worked with Mrs. W. Ballantyne, executive housekeeper of the hospital, on the contest entry; RONALD YAW, director of Blodgett Memorial Hospital, Grand Rapids, Mich.; DR. GEORGE W. JACKSON, superintendent of Arkansas State Hospital, Little Rock; SISTER MARY DOMINIC, R.S.M., administrator of St. John's Hospital, St. Louis; R. W. BACHMEYER, director of Aultman Hospital, Canton, Ohio; DR. FRANK C. SUTTON, director of Miami Valley Hospital, Dayton, Ohio; EUGENE F. J. KUHN, business manager of Tuberculosis Sanatorium Number 2, Cresson, Pa.; EDWIN H. PRESCOTT, assistant administrator of the Williamsport (Pa.) Hospital, and BOONE POWELL, administrator of Baylor Hospital, Dallas.

Architectural Exhibit

The American Institute of Architecture is planning an exhibit for the 52nd convention in Atlantic City which will consist of plans and/or models of hospitals built or in the designing stage since January 1, 1945. The architectural exhibit is a joint endeavor of the Association and architects' institute.

Entries to display plans and models at the convention are to be made by architects, not administrators, and must be in compliance with American Institute of Architecture regulations. Entry blanks must be returned to the American Hospital Association not later than August 10. Full details of the exhibit will be mailed to personal and institutional members of the Association.



MANY DELEGATES will stay at the Traymore Hotel in Atlantic City, convention headquarters.

Increase in Dues

At its June meeting, the Association's Board of Trustees voted to increase dues for personal and institutional members and to revise the personal membership requirements. These board recommendations will be submitted later to the Committee on By-Laws and to the House of Delegates and Assembly.

The dues of active Type I institutional members would be raised from $0.004 for the first 40,000 patient days and $0.002 for the next 70,000 patient days to a straight $0.006 per patient day, with a minimum of $45 and a maximum of $600 per annum.

Dues for personal members connected with institutional member hospitals would be increased from $5 to $7.50 per year.

Dues for other types of institutional and personal members were also recommended for change.

The board also acted to refuse personal membership in the future to individuals connected with eligible nonmember hospitals.

Council Structure Changed

The Board of Trustees last month voted a By-Laws amendment to provide that the membership of each Association council consist of nine persons, who shall serve staggered terms of three years each.

Effective with 1950-51, the functions previously assigned to the councils on association relations, public relations and education and to the Committee on Membership will be combined and transferred to a new council, to be known as the Council on Association Services.

This new council will (1) assist hospitals in improving their public relations and will stimulate better Association relations, educational activities and membership promotional efforts; (2) promote the values of all Association projects; (3) examine the Association's programs from the standpoint of their values to the entire membership;

(4) serve as the Association's membership committee, and (5) undertake such other activities as the Board of Trustees and the Committee on Coordination of Activities may assign it from time to time.

Blood Bank Action

The Association's trustees voted last month to establish a Committee on Blood Banking under the Council on Professional Practice. This committee will investigate the problems involved in operating blood banks in hospitals, will develop an Association policy with respect to these problems and will advise member hospitals in regard to their implementation.

The trustees also approved the program for a national blood transfusion service proposed by the National Security Resources Board. The Association will cooperate with the resources board in the standardization of equipment for blood transfusions nationally.

Pharmacy Standards

During its Chicago session last month, the Association's Board of Trustees voted approval of the Minimum Standards for Pharmacies in Hospitals, as revised by the Council on Professional Practice and approved by the Division of Hospital Pharmacy, representing the American Pharmaceutical Association and the American Society of Hospital Pharmacists.

The board also approved a survey of hospital pharmacies, to be conducted cooperatively by the Association, the Division of Hospital Pharmacy of the American Pharmaceutical Association, and the Public Health Service.

Accreditation Program

Association support was pledged by the Board of Trustees last month to the program of the American Association of Nurse Anesthetists in establishing an accreditation program for schools of nurse anesthetists. The nurse anesthetist organization may increase its membership dues $3 a year for maintenance of the program and is considering appointment of a fulltime educational director to oversee the program.

Proposed Manuals

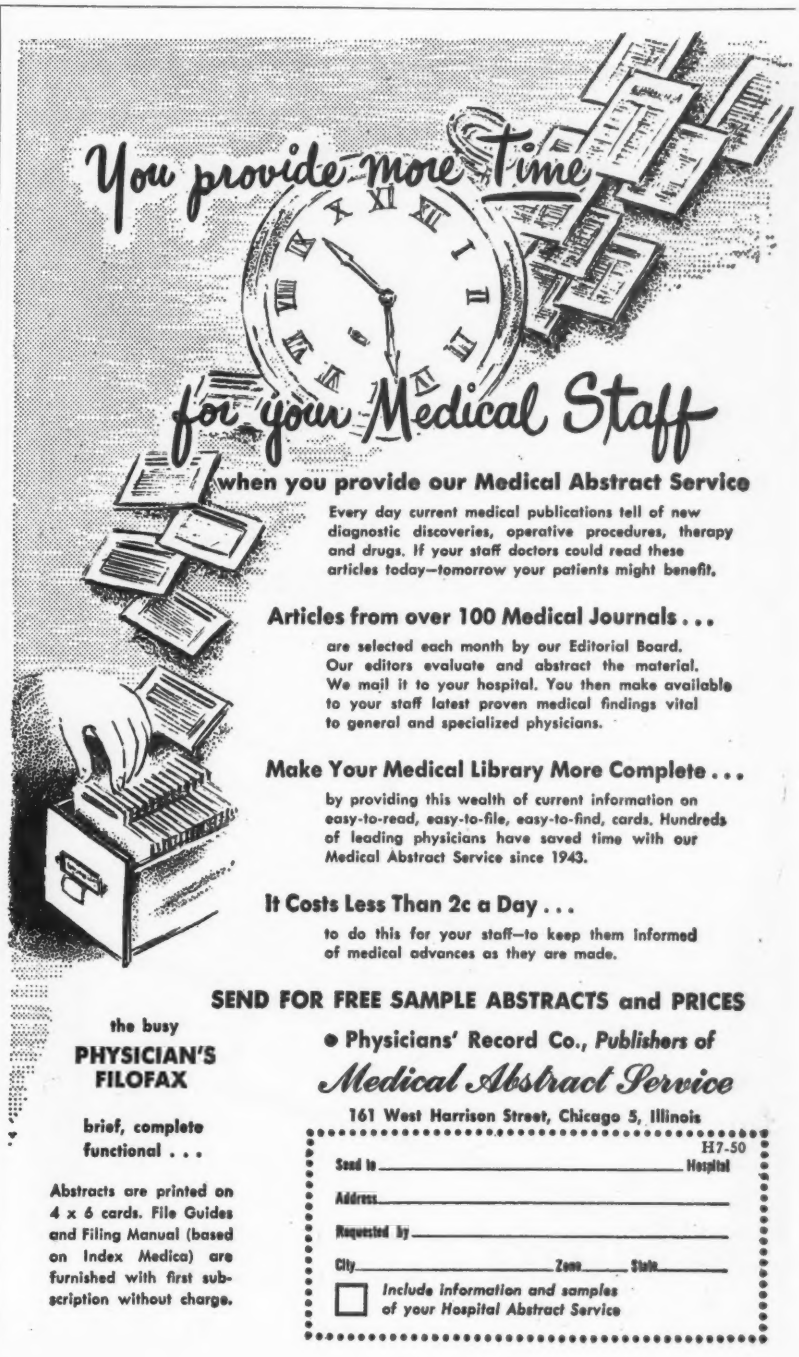
Two new manuals will be prepared as a result of action by the Board of Trustees last month.

The board approved preparation of a Manual on Organization of Women's Hospital Auxiliaries, with a model constitution and by-laws, for distribution to auxiliary members. The manual also will be made available to others wishing to purchase it.

The second manual will be on small hospital food service. The board recommended that the Association work with the American Dietetic Association to prepare the manual jointly. Development of the manual will be accomplished by the Joint Committee with the American Dietetic Association, and the manual will be submitted to both constituent organizations for final approval before being published.

Laundry Short Course

A short course in hospital laundry management will be offered at Iowa State University next year as a result of Association board ac-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tion last month. The trustees recommended that an attempt be made to find a sponsor who will contribute $3,000 to support the short course, with registration fees by students to be deducted from the amount of such a guarantee. If no sponsor is found, the Association will guarantee the minimum registration fees up to $3,000.

Insurance specialist: This action represented approval of a recommendation by the Council on Administrative Practice. The board endorsed another council request—that a fulltime insurance specialist be employed by the Association to coordinate hospital insurance activities. The board approved the recommendation in principle. Although funds are not now available for the employment of such a specialist, the trustees felt that such a move, if possible, would result in substantial savings for member hospitals.

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Hospital-Physician Relations

The Blue Cross Commission last month submitted to the Association trustees a statement defining the Blue Cross plans' position in relation to radiologic, pathologic, anesthesiologic and physiatric services. The Blue Cross resolution, as endorsed by the Board of Trustees, reads:

"The primary purpose of Blue Cross plans is to provide, on a prepayment basis, for those services which normally are a part of the cost of hospital care. The determination of what such services should be is a matter for which each hospital and its staff has the primary responsibility. Blue Cross plans should not permit themselves to be used as a device to force upon the public any definition of such services which is not generally applicable to all hospital patients in an area. The public service values of voluntary prepayment plans should not be sacrificed to gain ends for which the plans have no responsibility."

Social Security Stand

Support of the inclusion of employees of nonprofit hospitals under old age and survivors insurance benefits was voted by the Association's trustees last month. The board, at its Chicago meeting, recommended that all institutions be urged to make such benefits available to their employees provided that voluntary employee-employer participation is included in social security legislation.

The board also approved a Council on Government Relations recommendation that a letter be sent to the membership explaining the differences in the House and Senate versions of H.R. 6000, congressional social security bill, as it pertains to old age benefits for hospital employees.

Blue Cross Approval

A set of principles and standards for approval of Blue Cross plans was approved by the Association's Board of Trustees at its Chicago meeting last month. The principles and standards were adopted by the 1950 annual conference of Blue Cross plans, with changes suggested by the Council on Prepayment Plans and Hospital Reimbursement and the Blue Cross Commission.

These standards are to be incorporated into a licensing agreement, to be submitted to plans for signature. This licensing agreement will assign to the Association the responsibility for giving the

right to use the Blue Cross symbol and the words "Blue Cross" and for withdrawing such rights for violation of the standards.

Conciliation: Another board resolution instructed the Blue Cross Commission and the Council on Prepayment Plans and Hospital Reimbursement to do everything possible to facilitate fact finding and conciliation services as a substitute for arbitration procedures in the settlement of Blue Cross plan controversies. The board recommended also that arbitration procedures may be instituted by any body within the Association under special circumstances, but only after specific authority has been granted that body by the Board of Trustees to initiate arbitration arrangements.

School Data Analysis

The Association's trustees last month accepted the principal findings of the recent School Data Analysis Survey as a reasonably good presentation of nursing schools as they exist today, in consideration of the methods in which the data were collected. The board recommended that the National Committee for the Improvement of Nursing Service publish and make available to schools of nursing and other interested institutions a complete report of the School Data Analysis Survey.

New Staff Member

On July 1, Howard F. Cook was scheduled to join the headquarters staff of the Association as secretary of Association development. His position, a recently created one, will make him a liaison person between the headquarters and Association members and prospective members.

MR. COOK

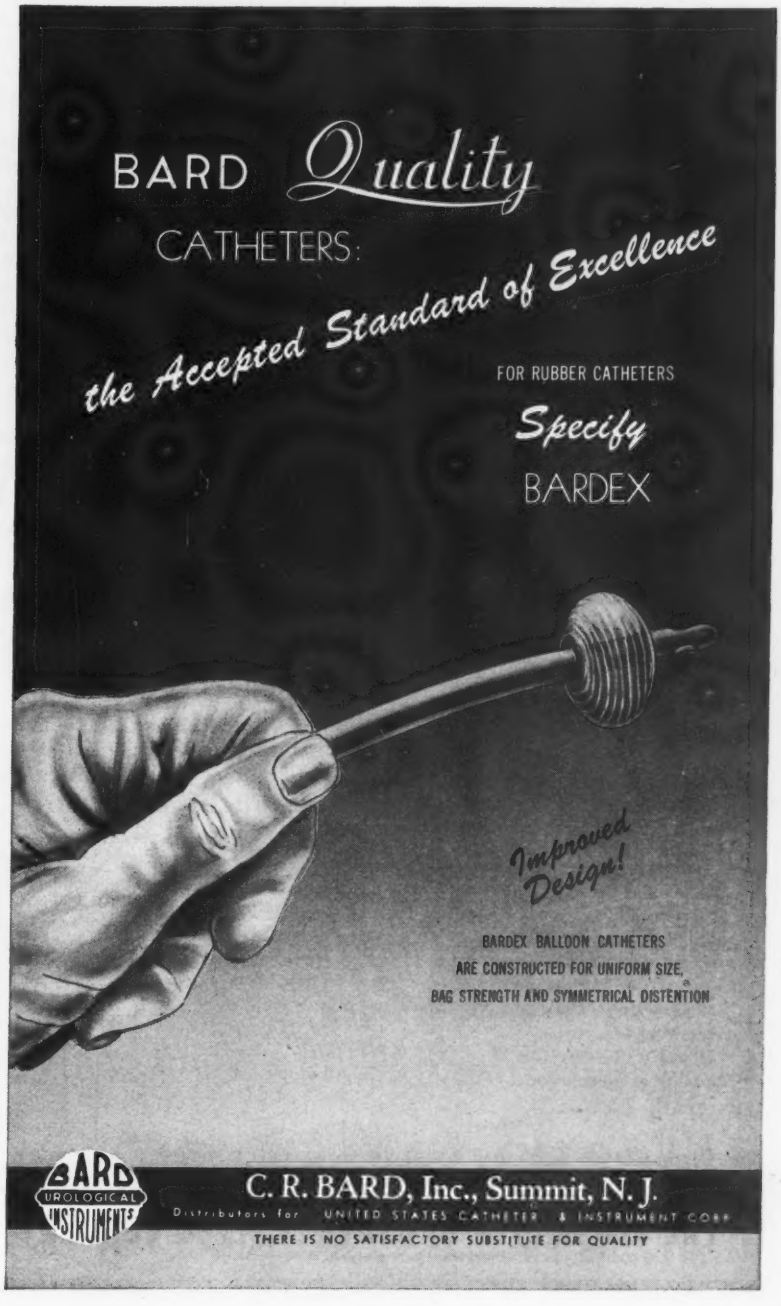
Mr. Cook is a 1948 graduate of the Northwestern University program in hospital administration, receiving the master of hospital administration degree with distinction. His undergraduate work was in business administration at the University of Missouri.

In recent years, Mr. Cook has been employed at Jewish Hospital, St. Louis, and Wesley Memorial Hospital, Chicago, gathering experience in five major departments of hospital administration. His administrative internship and residency were served at State University of Iowa Hospitals in Iowa City, where he worked with Superintendent Gerhard Hartman, Ph.D.

Immediately prior to his Association appointment and following his academic training, Mr. Cook was the administrative supervisor in charge of Children's Hospital, State University of Iowa Hospitals.

Purchasing Institute

Hospital purchasing agents in the Pacific area and western states will have the opportunity of attending a five-day institute at Stanford University, Palo Alto, Calif., July 31 to August 4. The institute for purchasing agents is being conducted by the American Hospital Association and sponsored by the Associations of Western Hospitals and of California Hospitals.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Stockpiling Supplies for Emergencies

Expected to be completed and widely distributed in the near future is a comprehensive itemized list of hospital supplies that would be needed in the event of an atomic bomb attack. The list is being prepared by the health resources division of National Security Resources Board.

Dr. Norvin C. Kiefer, head of the division, has discussed the question of hospitals' preparation for emergency — from the standpoint of drugs, blood, dressings and other expendable supplies—in several addresses in recent weeks. While pointing out that very few of the nation's hospitals now have stockpiles adequate to cope with a sudden emergency, Dr. Kiefer has emphasized that it would be unwise for institutions to launch large scale purchasing programs.

The supply list now in preparation will be based on a ratio of the number of items required per 1,000 casualties. Supplies listed will be those needed for first aid care only, as distinguished from follow-up and definitive treatment. Dr. Kiefer disclosed that when a tentative draft has been completed it will be submitted to representatives of American Hospital Association and certain other organizations for technical comment and criticism. Final adoption and distribution of the guide probably will not come for "a few months," Dr. Kiefer said.

He also pointed out that, in connection with civil defense planning, the wisdom of dispersing the country's hospital facilities, as well as its industrial plants, is to receive increased emphasis in the weeks to come. The Hill-Burton program, which has accelerated construction of hospitals in smaller cities and towns, is highly conducive to strategic objectives of civil defense planning, Dr. Kiefer asserted.

National Blood Programs

Absence from his duties, as a result of illness, of Dr. Norvin C. Kiefer during part of June was partly responsible for a delay in publicizing accomplishments of the first meeting of the new advisory board on development of a comprehensive national blood program. Formed by the National Security Resources Board, whose health resources division is headed by Dr. Kiefer, the committee met in Washington June 1 and 2.

Shortly afterward, General George C. Marshall, president of the American National Red Cross, announced reorganization of its national blood program. It has been separated from the Red Cross medical division and will be administered by a five-member committee of which Dr. Ross T. Mc-

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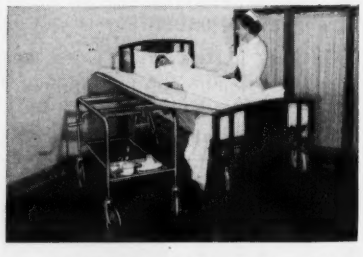

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Intire is chairman. Other members are Drs. Charles A. Doan, Ohio State University; Carl V. Moore, Washington University of St. Louis; Charles A. Janeway, of Harvard University, and I. S. Ravdin, University of Pennsylvania.

Veterans' Hospitalization

The first meeting of a special committee named by President Truman to study hospitalization problems of veterans, particularly paraplegics and amputees, was scheduled to be held in Washington June 19 and 20. Members of the group are Rear Adm. Robert L. Dennison, naval aide to the President; Dr. Howard A. Rusk of New York City, and Dr. Arthur Abramson, chief of physical medicine and rehabilitation, Bronx (N.Y.) Veterans Administration Hospital.

Mr. Ewing's Secrets

Federal Security Administrator Oscar R. Ewing last month used a hospital dedicatory address as a vehicle for telling two "secrets" about himself: He is "against socialized medicine" and he is "not wedded to national health insurance."

Speaking at the dedication ceremonies of a new wing and dispensary building at Brooklyn's Beth-El Hospital, Mr. Ewing took pains to condemn the principle of federal control of medicine and hospitals. To many, this came as a surprise, for Mr. Ewing is one of the chief supporters of national compulsory health insurance. But he assured his audience that *his* program would not mean federal control.

MR. EWING

Mr. Ewing then let his audience in on his first secret: "I am against socialized medicine. Perhaps I ought to repeat that slowly. I am against socialized medicine. I am against any system whereby all doctors work for the government and must treat the patients that the government sends to them. I am against any system whereby all patients—meaning the public—get their medical and hospital care paid for out of general taxes and must accept the treatment of the doctor that the government assigns to them."

Then came the expected "but."

"But I would not be fulfilling my responsibilities as Federal Security Administrator if I stopped there. . . . Good as our country's health is, it does not come anywhere near what it ought to be."

Then Mr. Ewing told his second secret. "I am not wedded to national health insurance," he said. "It is altogether conceivable to me that there is some better way to solve this problem than by the insurance method. I would gladly give up the proposal for national health insurance—and President Truman would gladly give it up—if someone would come along with a better way to do the job. . . . If someone has a better solution, let him speak up."

Many persons have spoken up. On page 37 of this issue, HOSPITALS presents a summary of the major health proposals that have been presented to the Eighty-first Congress, now in session.

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Thousands in use with never a criticism. We think you'll agree that it's priced too low at..... $69.50

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(Continued from page 89)

formerly was administrator of Leonard Morse Hospital, Natick, Mass.

HUBERT M. JOHNSON succeeded L. S. MESSICK as assistant director of James Walker Memorial Hospital, Wilmington, N. C., on June 15.

DR. ROGER B. NELSON will become assistant director of the University Hospital, Ann Arbor, Mich., on August 1.

Dr. Nelson has been on the administrative staff of the New York Hospital, New York City, since February, 1947. He served as executive assistant to the director, director of the outpatient department and later became assistant director of that institution.

Dr. Nelson is an active member of the American Hospital Association.

JAMES W. MCALVIN, administrator of Klickitat Valley Hospital, Goldendale, Wash., was appointed administrator of Douglas Community Hospital, Roseburg, Ore., on June 1.

The Douglas Community Hospital is now under construction and will be completed next November.

The following appointments were announced recently by the Veterans Administration:

DR. CLARENCE R. MILLER, manager of the Veterans Administration Hospital, Jackson, Miss., has become manager of the 200-bed Veterans Administration hospital under construction in Marlin, Tex.

DR. CLIFTON H. SMITH has been appointed manager of the Oliver General Hospital, Augusta, Ga., which the Veterans Administration acquired from the Army on June 30. Dr. Smith previously served as manager of the Veterans Administration Hospital, Atlanta.

DR. JOHN H. HOOD, manager of the Veterans Administration Hospital, Chamblee, Ga., has succeeded Dr. Smith at the Veterans Administration Hospital in Atlanta.

WALTER R. ARMSTRONG has been named chief of special services at the Veterans Administration Hospital, Shreveport, La. Prior to this appointment, Mr. Armstrong was assistant director of special services for the southwestern area office of the Veterans Administration, St. Louis.

DR. ERNEST V. EDWARDS, manager of Birmingham Veterans Administration Hospital, Van Nuys, Calif., has been appointed manager of U. S. Naval Hospital, Long Beach, Calif. The Veterans Administration will acquire the Long Beach hospital upon completion of arrangements with the Navy, which abandoned the hospital on June 30.

DR. J. RALSTON WELLS has become manager of the Veterans Administration Hospital, under construction at Grand Island, Neb.

DR. FREDERIC R. EASTLAND has succeeded Dr. Wells in his former position as manager of the Veterans Administration Hospital in Dallas. Dr. Eastland was chief of professional services at the Veterans Administration Hospital, Lake City, Fla., and has been with the Veterans Administration since 1931.

NELSON HEDRICK, formerly administrative assistant at the Manhattan General Hospital, New York City, became assistant superintendent of the Jewish Sanitarium and Hospital for Chronic Diseases, Brooklyn. Mr. Hedrick served as an administrative intern at Lenox Hill Hospital, New York City.

OMER B. MAPHIS was appointed administrator of Greene County Memorial Hospital, now being constructed in Xenia, Ohio. For the last four years, Mr. Maphis served as administrator of Kenosha (Wis.) Hospital. Prior to that, he was superintendent of Deaconess Hospital, Freeport, Ill.

JOHN D. THOMPSON was to have become assistant director of Montefiore Hospital, New York City, on July 1. He received his master's degree in hospital administration from Yale in June and recently completed his administrative residency at Montefiore Hospital.

HARRY M. PIPER JR. became assistant to the director of St. Luke's Hospital, St. Louis, Mo., on June 15. Prior to this appointment, he was publicity director of the St. Louis Chamber of Commerce.

DELIGHT S. JONES has been appointed administrator of Kent County Memorial Hospital, now being constructed in Warwick, R. I. Prior to this appointment, she served as administrator of Truesdale Hospital, Fall River, Mass. Mrs. Jones is a member of the American College of Hospital Administrators, American Nurses' Association and the American Hospital Association.

JOHN L. BECKWITH became assistant administrator of Highland Hospital, Rochester, N. Y., on June 1. Mr. Beckwith received his degree in hospital administration from the course at the University of Minnesota and served his administrative residency at Syracuse (N. Y.) Memorial Hospital.

MARGARET ROUILLION became director of social service at St. Luke's Hospital, New York City, on May 1. She succeeded GRACE COOKE, who has retired after having served as director of that department for 11 years.

As a medical social worker, Miss Rouillion has been with the surgical and orthopedic services of St. Luke's Hospital since 1937. For the past five years she has been on the executive committee of the North Atlantic District of the American Association of Medical Social Workers.

PETER L. SCOTT became assistant administrator of Fitkin Memorial Hospital, Neptune Township, N. J., on June 15. He recently completed his administrative residency at East Orange (N. J.) General Hospital.

JOSEPHINE A. MULVILLE, R.N., plans to retire this summer as superintendent of the New England Hospital for Women and Children, Boston. She has been superintendent of that institution since 1935.

Prior to that time, Miss Mulville served as superintendent of Framingham (Mass.) Hospital and as

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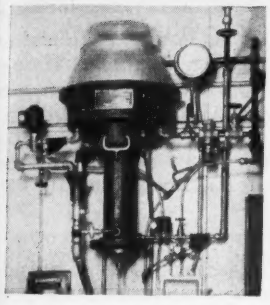

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- Public Room Furniture
- Sealed Pictures
- Semi-Private and Ward Groupings
- Story Wall Pictures

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assistant superintendent of Beth Israel Hospital in Boston, where she organized the school of nursing and became its director.

She is a member of the American College of Hospital Administrators and the American Hospital Association.

MARTIN S. ULAN became assistant administrator of Hackensack (N. J.) Hospital on June 1. Mr. Ulan has been on the faculty of Rutgers University School of Pharmacy for the past 11 years. He is a past-president of the New Jersey Branch of the American Pharmaceutical Association and is secretary of the American College of Apothecaries.

CARL NUSBAUM has been named administrative assistant of Mount Sinai Hospital, Chicago. He previously was assistant personnel director of Michael Reese Hospital, Chicago.

DR. OSWALD J. MCKENDREE, supervising psychiatrist of the Utica (N. Y.) State Hospital since 1940, has become assistant director of Pilgrim State Hospital, West Brentwood, L. I., N. Y.

He had been serving as acting assistant director of Utica State Hospital for the past several months.

EDITH COONTZ, R.N., has succeeded MARGARET MILLER as superintendent of The Norwalk (Ohio) City Hospital. Miss Miller, who had served in that position for the past three years, became superintendent of H. B. Magruder Memorial Hospital, Port Clinton, Ohio on June 1.

Correction

A personal news item on this page in June erroneously stated that RAYMOND E. HOSFORD had succeeded ALBERT M. HEYBERGER as assistant superintendent of Bradford (Pa.) Hospital.

The item should have stated that Mr. Hosford, a fellow of the American College of Hospital Administrators, is superintendent of Bradford Hospital and has served in that position since 1932.

Mr. Heyberger now is assistant administrator of Baroness Erlanger Hospital, Chattanooga, Tenn.

Deaths

GRANT H. POUND, administrator of St. Joseph Michigan Hospital, St. Joseph, died May 13. A member of the American College of Hospital Administrators, Mr. Pound had previously been credit manager of Hurley Hospital, Flint, Mich.

H. HERSCHEL LEITER, president of DePuy Manufacturing Company, Warsaw, Ind., died on May 8 at Nashville, Tenn.

He was well known for his development of appliances for fracture therapy.

DR. UBALDO E. ZAMBARANO, for nine years superintendent of State Sanatorium, Wallum Lake, R. I., died May 29. He resigned as superintendent in 1948 to become executive secretary of the Providence Tuberculosis League.

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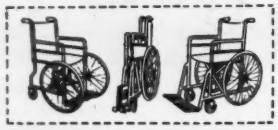

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